

POETICS, CREATIVITY, AND THE EMBEDDEDNESS OF AMERICAN ACUPUNCTURE

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Abstract

This dissertation argues that acupuncture is not simply a traditional East Asian medical modality that is being translated into a new context but instead that the terms of its operation and therapeutic efficacy are constantly being reconfigured in the interplay between notions of cultural difference and the concrete experiences of illness. This argument is based on three years of ethnographic study in four different acupuncture clinics in the United States and is developed through analysis of 1) perspectives shared by patients and practitioners, 2) medical and popular printed materials about acupuncture in the 19th and 20th centuries, 3) physical spaces and material objects in acupuncture clinics, 4) two case studies of acupuncture patients that focuses on the use of diagnostic terminology. The ethnographic findings of this dissertation are explored using concepts such as knowing and awareness (chapter 1), practical medicine (chapter 2), poetics (chapters 3 and 4), and culture (chapter 5). These ethnographic findings and conceptual frameworks highlight the creative aspects of American acupuncture while also tracing the complex ways in which the practice has been embedded into the therapeutic landscape of the United States.

Primary reader and advisor: Naveeda Khan

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Dedication

For all those involved in acupuncture with whom I have had the privilege of working.

This dissertation comes from you and so is for you.

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Introduction:

Acupuncture, efficacy, and ethnography

In the spring of 2008, I was working as an acupuncturist in a small three-room clinic in northern Virginia. The clinic was tucked away in the corner of the lobby of a large hospital center and could be difficult to find. Although the location lacked visibility, it was convenient for patients who might not otherwise use acupuncture. Cancer patients could schedule acupuncture appointments immediately before or after their regular chemotherapeutic treatments. Expectant mothers whose labor had stalled could simply take the elevator down from the labor and delivery department to receive acupuncture for labor induction.

Many patients shared their curiosity about the state of acupuncture research with me. Usually, they would introduce the topic by mentioning a popular news article that reported on a recently concluded study. One week, a surprisingly large number of patients wanted to talk about clinical trials of acupuncture. While some mentioned a study that had just shown acupuncture to be very effective for back pain, just as many talked about a study that had shown that acupuncture was, in fact, ineffective for back pain. My curiosity piqued, I went in search of these studies to evaluate them for myself. Because clinical research into acupuncture can be a tricky endeavor, I expected to find methodological differences that might account for these contradictory findings. To my amusement, the “two” studies were actually, two very different journalistic interpretations of the same study: Haake et al’s “German acupuncture trials (GERAC)

for chronic low back pain.”¹

The GERAC study involved three different trial groups: one received “true acupuncture,” another received “sham acupuncture,” and a third received “conventional treatment.” True acupuncture meant that patients were needled “according to principles of traditional Chinese medicine.” Sham acupuncture involved “superficial needling at non-acupuncture points.” The “conventional treatment” was a “combination of drugs, physical therapy and exercise” selected and administered according to established German biomedical guidelines. After six months, the key assessment was a “response rate” designed to measure decreases in pain. True acupuncture had a 48% response rate, sham acupuncture had 44%, and conventional therapy had 27%. Based on these results, the researchers concluded that true acupuncture is superior to conventional treatment for back pain: “to our knowledge, this is the first time superiority of acupuncture over conventional treatment has been unequivocally demonstrated for the primary and secondary outcomes, including medication reduction, in contrast to studies with a usual care group.”² Yet the very next sentence of the paper adds that “there was essentially no difference between the results for verum and sham acupuncture.” Journalistic accounts of the study focused on either the first claim or the second but not both. In the acupuncture research world, the size (n=1162) and rigor of the GERAC study has meant that its contradictory findings cannot

¹ Haake, Michael, Hans-Helge Müller, Carmen Schade-Brittinger, Heinz D. Basler, Helmut Schäfer, Christoph Maier, Heinz G. Endres, Hans J. Trampisch, and Albrecht Molsberger. 2007. “German acupuncture trials (GERAC) for chronic low back pain: Randomized, multicenter, blinded, parallel-group trial with 3 groups.” *Archives of Internal Medicine* 167 (17): 1892–1898.

² Haake et al, “German acupuncture trials,” 1896.

be easily brushed aside. Furthermore, similarly designed studies such as Brinkhaus et al,³ Thomas et al,⁴ and Cherkin et al,⁵ have recorded similar results.

The GERAC study exemplifies a longstanding methodological concern within the acupuncture research community over what constitutes a proper control group. A white paper written by board members of the Society for Acupuncture Research (SAR) and published in 2011, summed up the problem neatly: “a large number of well-designed clinical trials have reported that true acupuncture is superior to usual care, but does not significantly outperform sham acupuncture, findings apparently at odds with traditional theories regarding acupuncture point specificity and needling technique.”⁶ The paper calls this one of the central “paradoxes” of current acupuncture research. When patients led me to the GERAC clinical trial in 2008, I was already contemplating a turn from the practice of acupuncture to its ethnographic study. Although medical research has provided significant insights into the mechanisms of acupuncture, each new finding seems to also uncover a new contradiction that has stymied interpretation. Researchers always seemed to be taking two steps forward, one step back, then one step in a random direction.

³ Brinkhaus, Benno, Claudia M. Witt, Susanne Jena, Klaus Linde, Andrea Streng, Stefan Wagenpfeil, Dominik Irnich, Heinz-Ulrich Walther, Dieter Melchart, and Stefan N. Willich. 2006. “Acupuncture in patients with chronic low back pain: A randomized controlled trial.” *Archives of Internal Medicine* 166 (4): 450–457.

⁴ Thomas, K. J., H. MacPherson, L. Thorpe, J. Brazier, M. Fitter, M. J. Campbell, M. Roman, S. J. Walters, and J. Nicholl. 2006. “Randomised controlled trial of a short course of traditional acupuncture compared with usual care for persistent non-specific low back pain.” *BMJ* 333 (7569): 623–629.

⁵ Cherkin, Daniel C., Karen J. Sherman, Andrew L. Avins, Janet H. Erro, Laura Ichikawa, William E. Barlow, Kristin Delaney, Rene Hawkes, Luisa Hamilton, and Alice Pressman. 2009. “A randomized trial comparing acupuncture, simulated acupuncture, and usual care for chronic low back pain.” *Archives of Internal Medicine* 169 (9): 858–866.

⁶ Langevin, Helene M., Peter M. Wayne, Hugh MacPherson, Rosa Schnyer, Ryan M. Milley, Vitaly Napadow, Lixing Lao, Jongbae Park, Richard E. Harris, and Misha Cohen. 2011. “Paradoxes in acupuncture research: Strategies for moving forward.” *Evidence-Based Complementary and Alternative Medicine*. 2.

The perplexity aroused by clinical trials contrasted sharply with my experience as a practitioner. Although acupuncture's effects could be confusing or at times frustrating, my sense of its workings was becoming increasingly coherent. In practice, the effects of acupuncture are often ephemeral. They are difficult to comprehend but relatively easy to grasp in the moment of a clinical encounter and in the context of a therapeutic relationship between patient and practitioner. Ethnography seemed to be the ideal method for investigating the interplay between sensation, experience, materiality, and social relations in the course of therapy. Instead of examining these components in isolation, ethnography, as I understood it, promised to cultivate a field of inquiry around them. This dissertation is, at its core, an attempt to fulfill that promise.

Surveying a field of inquiry

The dissertation is organized around two related questions: What kind of therapeutic activity is acupuncture? and how does the practice fit into the broader landscape of American medicine? These were not the questions that I began with when I set out to do fieldwork but were formulated over time. For this dissertation, I imagine ethnography as a means of producing meaningful questions as much as a method of settling on answers. To get a better sense of how I cultivate this field of inquiry, I will survey questions that are already being asked of acupuncture, consider why they are

being asked in a particular way, and wonder how they might be asked differently.

I will begin by looking at the GERAC study and how its investigation relies on the difference between true acupuncture (associated with the principles of “traditional Chinese medicine”) and the mere insertion of needles into the body (i.e. sham acupuncture). This way of formulating acupuncture raises an important problem in thinking about this type of sham as a control. Many Japanese and Korean schools of acupuncture employ superficial needling at point locations that would be considered non-standardized according to Chinese systems of the meridians. Might the “sham acupuncture” that appears in the GERAC study be better understood in relation to a Japanese or Korea style?

A second crucial question raised by the GERAC study is how acupuncture is both associated and differentiated from “conventional” biomedical practices. The study design distinguishes acupuncture from biomedicine by separating the verum treatment group from the conventionally treated group. At the same time, the very fact that the study is designed according to biomedical principles of evaluation (particularly that of the randomized controlled trial) means that acupuncture is being tested from within a distinctively biomedical research program. Such research requires that a specific therapeutic action be isolated then duplicated across a set of functionally identical conditions and compared with a control intervention.

Perhaps ironically, it is Chinese medicine that is used to identify the components of therapeutic action and thus enable the study to be set up in scientific terms. The difference between verum and sham techniques relies on a particular form of

therapeutic reasoning about acupuncture that is based on Chinese medical “principles” of where, how deeply, and how long needles are to be placed for a particular disorder. Thus, Chinese medicine, far from opposing the scientific basis of a clinical trial, furnishes the very differences that become the object of its investigation. Yet, these trials ignore Chinese medical ideas of what constitutes therapeutic efficacy—of how and when to recognize outcomes. Case studies and clinical experience, rather than controlled trials, form the basis of Chinese medical thinking about efficacy.

It must be said that scientific research into acupuncture has not always taken Chinese medicine so seriously. Writing of the state of acupuncture research in 1986, Nathan Sivin critiqued the “freely expressed ignorance” that many researchers had of traditional theories.

The functions of advising, setting standards, and providing peer review that are ordinarily entrusted to experts fell almost entirely into the hands of people who did not feel that they needed to master the special techniques and concepts of Chinese medicine to put themselves forward as experts on it. None, so far as I can discover, was trained to the standard that Chinese expect of a village doctor. The results of the research were predictably as chaotic as if groups in China were to try our techniques of local anesthesia in abdominal surgery without first mastering anatomy and physiology... What if a qualified traditional physician, or someone who thoroughly understood Chinese therapeutic reasoning, had been involved in the early deliberations?” The research sponsored would have

been more realistic in its claims, more deliberately paced, more critically evaluated, and more productive.⁷

Much of the acupuncture research that took place in the United States in the 1970s and 1980s assumed that acupuncture could be understood as a surgical procedure whose effects would be explained in terms of biomedical physiology. Thus, many investigators at the time sought to uncover the physiological mechanism behind acupuncture's obvious efficacy. The failure of that early phase of acupuncture research, as Sivin saw it, could have been mitigated if acupuncture had been conceived in conjunction with culturally inflected techniques and concepts.

The next phase of research on acupuncture, which culminated in studies like GERAC, favored incorporating forms of therapeutic reasoning that are rooted in East Asian traditions and cultures. And yet, with this new wave of research has come a new wave of failures. Recent findings have flown in the face of the expectations expressed by Sivin. Cherkin et al concluded that "collectively, these recent trials provide strong and consistent evidence that real acupuncture needling using the Chinese meridian system is no more effective for chronic back pain than various purported forms of sham acupuncture."⁸ If the traditional principles of acupuncture were being compared with sham acupuncture alone, the interpretation would be simple: acupuncture is no more effective than placebo and therefore ineffective. The complication is that studies like

⁷ Sivin, Nathan. 1986. "Traditional Chinese medicine and the United States: Past, present, and future." *Bulletin of the American Academy of Arts and Sciences* 39 (8): 15–26. 22.

⁸ Cherkin et al, "A randomized trial comparing acupuncture, simulated acupuncture, and usual care for lower back pain," 864.

GERAC and Cherkin et al also test acupuncture against biomedical treatments that have themselves already been validated as effective in controlled trials. Several researchers, most notably Ted Kaptchuk, have suggested that these paradoxes stem not from problems of modeling acupuncture but from problems of modeling placebos.⁹

The authors of the SAR paper suggest that future research could find a way around this paradox by better differentiating between what they call the “specific” and “non-specific” components of practice. Specific factors are elements of causative therapeutic actions such as “[point] location, insertion depth, stimulation, needle size and number”¹⁰ that can be isolated from the context of use. Nonspecific factors, such as “time, attention, credibility, and expectation,”¹¹ have effects that are not yet known, cannot be isolated, or only operate in the context of a particular clinical encounter. One of the central questions raised by the SAR paper is whether the contradictions of clinical research trials arise because study designs have not adequately identified the specific components of acupuncture or because the mechanisms of acupuncture are essentially nonspecific.

Ethnographic approaches to Chinese medicine have asked similar questions but from a very different direction. Clinical research tends to take the idea of Chinese medicine as a conceptual system for granted in order to use it as a resource for identifying the specific components of acupuncture. Anthropologists, on the other hand, are connoisseurs of the social contexts of medicine, of the relational aspects of its

⁹ Kaptchuk, Ted J., Peter Goldman, David A. Stone, and William B. Stason. 2000. “Do medical devices have enhanced placebo effects?” *Journal of Clinical Epidemiology* 53 (8): 786–792.

¹⁰ Langevin et al, “Paradoxes in acupuncture research,” 4.

¹¹ Ibid, 4.

encounter, and of the complexities of its logic—in a word, the nonspecific. For ethnographers like Judith Farquhar,¹² Volker Scheid,¹³ Mei Zhan,¹⁴ Elizabeth Hsu,¹⁵ and Sonya Pritzker,¹⁶ Chinese medicine is a nuanced system that is to be understood not by isolating components but by observing and participating in the irreducible complexity of its institutions and practices.¹⁷ Their insights have repeatedly challenged the possibility of thinking about Chinese therapeutic reasoning as a coherent system. They show how this decoherence can be attributed to, on the one hand, a heterogeneity that has historically been characteristic of Chinese medicine, and on the other, the conditions of globalized modernity in which these medical practices are currently embedded.

Certainly, all expert practices involve some level of decoherence and disagreement be they regional differences or competing theoretical frameworks. Emphasis on the role that such differences can play in an otherwise stable system or institution has been a hallmark of many social scientific studies of even the most coherent forms of scientific expertise. Even so, acupuncture is remarkable for the fact that master acupuncturists often disagree over the most basic aspects of practice, such as point location. At a clinical seminar on orthopedic acupuncture in 1995, the well-known acupuncturist Mark Seem explained just how much trouble he encountered while helping to develop national standards for acupuncture certification in the United

¹² Farquhar, Judith. 2018. *Knowing practice: The clinical encounter of Chinese medicine*. Routledge.

¹³ Scheid, Volker. 2002. *Chinese medicine in contemporary China: Plurality and synthesis*. Duke University Press.

¹⁴ Zhan, Mei. 2009. *Other-worldly: Making Chinese medicine through transnational frames*. Duke University Press.

¹⁵ Hsu, Elisabeth. 1999. *The transmission of Chinese medicine*. Cambridge University Press.

¹⁶ Pritzker, Sonya. 2014. *Living translation: Language and the search for resonance in US Chinese medicine*. Berghahn Books.

¹⁷ I will discuss the work of these authors in more detail in the first chapter.

States.

In the national boards, I was chair of the committee that developed that horrendous test that you students probably all hate—the point location exam. It was my last act after seven years of being on the commission. I was totally opposed to the exam so I really stirred up a hornet's nest, which is what I tend to like to do.

All the people there were experts from every tradition in America, every tradition that could be found. Many older Asian practitioners said that the best way to set up a test would be to find points on real people and mark it with invisible ink. The testing service that was helping us develop the exam said, “okay, at the end of the day, we’re going to shine a black light on those models and we’re going to draw a circle around the entire area where there are dots. You’re all experts. This shouldn’t be too bad.” And, I said, “oh you’re wrong. Be ready for a big surprise.”

A few of my colleagues, whom I no longer speak to anymore because this was such a bitter thing here, they thought we were going to come up with areas the size of a pea because these are experts. You students could do it within the size of a pea. If someone said to you, “know these 50 points and you’re going to find them on a person within a pea?”—no problem. If you’re told ahead of time?—piece of cake. We were also told which books to use. So, it wouldn’t even be like different traditions. Use those books. Great. And, the thing could be done

open-book. You could go in with the model, open the book, and find the point.

Well at the end of the day, the best point was Lung 9, which was the size of a quarter.¹⁸ Lung 9. A quarter. That seems hard to believe. That's bigger than seems possible. You're into the tendon by then. You're off the wrist.

Unbelievable. But, I knew this would happen. The mu and shu points?¹⁹

Especially the shu points—grapefruit. So, one of my colleagues who I don't talk to anymore said, "well this is easy" and started going in removing points saying, "this one's stupid, this one couldn't be it, that one couldn't be it." And so I asked, "who put this *stupid* point here?" Kiko [Matsumoto] would go, "that's mine."

And I go, "oh so Kiko doesn't count in American acupuncture. She's not an expert. She doesn't know how to find points on people." That stirred it up. And, "whose is this?" The stupid points always belonged to these real master Asian practitioners. Mine were right on, by the way, because I do it the way I'm told, as a good boy, as a lot of the Americans did. But, these masters couldn't be made to do that because they didn't understand the stupidity of that. And, they weren't being revolutionary either. They were like, "no, they're not inviting me here to find points by reading a book. That's too stupid to even do. You don't fly somebody in from all over the world to do that. Get that book off the table.

Here's the point."

So when we stirred up the discussion that I wanted to stir up, I said, "okay, so

¹⁸ Lung 9 is a point in the radial end of the wrist crease.

¹⁹ Mu and shu points are classes of commonly used points that are found on the back of the body alongside the spine and on the front of the torso.

what do you think? I mean, are some of you still inebriated from last night? What's going on here?" And so one person said, "I'm going to go farther than that. I mean, I did put a dot there. My dot's there but, quite frankly, that patient doesn't have triple heater five."²⁰ I said, "oh now it's getting interesting. What do you mean?" And he said, "it wasn't reactive." And then one of the commissioners said, "you weren't supposed to press hard." The practitioner was offended. He said, "I don't press. I just look. And that's not reactive. They don't have triple heater five." I said, "anybody else in here agree with that?" Several Asians said, "Absolutely. No triple heater five." I said, "Good, I agree totally." And, that was it. Two commissioners never talked to me again.²¹

There is a divide in Seem's story between the "good Americans" like himself who have at least a grudging respect for the value of consensus and the "real master Asian practitioners" who reject consensus for consensus sake. Such masters have little expectation or even aspiration for finding agreement over the basic terms of practice.

The history of acupuncture is filled with competing schools of medical practice that feature wildly different approaches, outlooks, and techniques. Stephen Birch has claimed that Chinese medicine is not a coherent system but a "multimodal system of healing with multiple competing explanatory models."²² The idea has been supported

²⁰ Triple heater five (TB 5, Waiguan) is a major acupoint on the posterior forearm.

²¹ Seem, Mark. *Acupuncture Osteopathy: A meridian approach to myofascial and zang fu problems*, (1995; Portland: OCOM), Video recording, <https://vimeo.com/album/3822571>.

²² Birch, Stephen. 1998. "Diversity and acupuncture: Acupuncture is not a coherent or historically stable tradition." In *Examining Complementary Medicine*, edited by Andrew Vickers, 45-63. Nelson Thornes.

by a range of works, most notably Paul Unschuld,²³ Schield,²⁴ and TJ Hinrichs and Linda Barnes.²⁵ Farquhar recounts in her ethnography of the Chinese medicine in China in the early 1980s how when she would ask her teachers about contradictions in Chinese medical theory, “invariably the answer was ‘we take experience [jingyan] to be our guide,’ or, rebuking me for my literal-mindedness, ‘We take practice [shijian] to be the main thing.’”²⁶

My experience studying acupuncture in American schools in the early 2000s was very similar to Farquhar’s. In classes and exams, I knew to expect a form of Chinese medicine based on the standardized “Traditional Chinese Medicine” (TCM) developed by Chinese medical institutions in the 1970s and 1980s. In the clinic, however, I witnessed my teachers employing radically different styles and techniques to great effect, sometimes even on the same patient or for different people with the same problem. As an apprentice to these experienced practitioners, I learned that to attempt to uncover “true” acupuncture and Chinese medicine from what might be considered its more incidental elements is to navigate a heterogeneous field of concepts and techniques. Therefore, it should be said that the question of how to choose an approach from among competing theories is as salient for the clinician as it is for the researcher. And in some ways, the challenges faced by students and practitioners of acupuncture are greater because they are not surveyors but inhabitants of this landscape.

²³ Unschuld, Paul. 2010. *Medicine in China: A history of ideas*. University of California Press.

²⁴ Scheid, *Chinese medicine in contemporary China*.

²⁵ Hinrichs, T.J. and Linda L. Barnes, eds. 2013. *Chinese medicine and healing: An illustrated history*. Harvard University Press.

²⁶ Farquhar, *Knowing practice*, 1.

Even if we could assume that there was once a historical period, geographical location, or social body in which something like “true” acupuncture and Chinese medicine could be found, contemporary Chinese medicine in the United States cannot be isolated from the broader institutions of American medical practice. If we look, for example, at what the SAR white paper lists as nonspecific components of practices, we see things like the attention of the therapist, the credibility of the practice, and the expectations of the patient. These components are indelibly marked by acupuncture’s status as an “alternative” medicine, a designation that means that Chinese medicine and other systems of so-called Complementary and Alternative Medicines (CAM) stand both within the American system of medical professions and outside of it.

Posing questions

I return then to the two central questions noted earlier: what kind of therapeutic activity is acupuncture? and how does the practice fit into the broader landscape of American medicine? In this ethnography, these questions organize my descriptions of acupuncture practice, clinical space, the history of acupuncture in the United States, and the experiences of its patients and practitioners.

What kind of therapeutic activity is acupuncture?

Although this question is rarely asked and seldom explicitly answered, different groups

exhibit very different ideas about what kind of activity acupuncture is. We can see evidence of these differences in the ever-proliferating ways of classifying acupuncture. Acupuncture is commonly called traditional, natural, alternative, holistic, evidence-based, pseudoscientific, cultural, counter-cultural, Chinese, Japanese, and East Asian. Acupuncture has even been thought of at different historical moments as a practical form of surgery, a French medical innovation, or even as a psychological technique.

As I described with respect to the GERAC study and the SAR paper, contemporary clinical researchers imagine acupuncture as a medical intervention in which a practitioner implements an instrumental therapeutic logic. This approach is designed to isolate the mechanisms and specific components of acupuncture for trial. Seem's anecdote about developing a national board exam gives a sense of how acupuncture might be seen by commissioners and testing specialists as the basis of a profession whose techniques can be standardized and tested against a body of knowledge.

Researchers and regulators tend to see acupuncture as functioning in an imperative mood, an assumption in keeping with their approaches to biomedicine. Talcott Parsons gives an excellent example of this way of framing medical practice in his essay on the role of the physician in Western society.²⁷ Parsons claims that healthcare providers think about their work as "the simple application of technical

²⁷ Parsons, Talcott. 1951. "Illness and the role of the physician: A sociological perspective." *American Journal of Orthopsychiatry* 21 (3): 452–460.

knowledge of the etiological factors in ill health and of their own manipulation of the situation in the attempt to control these factors.”²⁸ The specifics of acupuncture knowledge may differ from that of biomedicine but each can still be modeled as a complex therapeutic machine. It is not hard to imagine acupuncturists as expert operators of this machine for whom the acupoint is a kind of button.

Seem portrays a different way of seeing acupuncture, one that works in personal and interpersonal terms and approaches acupoints not as buttons but as openings or media through which mutual interactions take shape. In this way, acupuncture can be seen as functioning in a more expressive and dialogic mode. Its practice resembles a theatrical performance in which the acupoint is delivered like a line of dialog. Ask 20 great actors to read a line or convey an emotion and they may give 20 different but equally “effective” performances. Perform the same play 20 nights in a row and each may produce a different response in the audience. Acupuncture here is not an action but a reaction, an activity, or a collaborative performance.

I should be careful, however, not to paint these different camps with too broad a brush. The very notion of nonspecific effects can indicate that the clinical models of researchers are not limited to those of isolated technical therapeutic actions. The idea of nonspecific effects may be a rickety bridge built on a negative basis (i.e. a collection of actions that cannot be specified) but it is a potential bridge nonetheless. The advantage of anthropological theory is that it offers a range of positive terms for thinking about the nonspecific. We can think about these effects in terms of contexts, relations,

²⁸ Parsons, “Illness and the role of the physician,” 452.

performances, pluralities, or dialogics to name a few possibilities.

The ethnography that follows takes these different perspectives seriously but its sympathies favor practitioners, patients, and the ways in which they relate in the context of clinical encounters. My investigation tends to focus on creativity, playfulness, and collaboration. Thinking about acupuncture as a creative rather than learned profession minimizes the instrumental aspects of practice in favor of seeing the practitioner as an artist/producer who collaborates with the patient/audience.

The concept of creativity is a slippery one, however. Margaret Boden, who has written extensively on creativity from within cognitive science, frequently introduces the concept with some version of the idea that “creativity is a puzzle, a paradox, some say a mystery... [that] seems to outlaw any systematic explanation, whether scientific or historical.”²⁹ Coming from a more anthropological angle, John Liep defines creativity as “activity that produces something new through the recombination and transformation of existing cultural practices or forms.”³⁰ Liep is interested in questions of form or, to extend his analysis, with the suggestion that creativity is a way of interrogating of form. In this sense creativity is a way of asking: what are the limits of a form? What forms are possible? What relations can be made between different forms? The notion of form is also critical to Timothy Ingold’s approach to creativity^{31,32,33} both as an aspect of ethnographic methods as well as an object of study. Ingold approaches the idea of

²⁹ Boden, Margaret. 2013. “Creativity and computers.” In *Artificial Intelligence and Creativity: An Interdisciplinary Approach*, edited by Terry Dartnall, 3–26. Springer Science & Business Media. 3.

³⁰ Liep, John. 2001. “Introduction.” In *Locating Cultural Creativity*, 1–14. Pluto Press. 2.

³¹ Hallam, Elizabeth, and Timothy Ingold, eds. 2007. *Creativity and cultural improvisation*. Berg.

³² Ingold, Timothy. 2014. “The creativity of undergoing.” *Pragmatics & Cognition* 22 (1): 124–139.

³³ Ingold, Timothy. 2009. “The textility of making.” *Cambridge Journal of Economics* 34 (1): 91–102.

creativity by stepping away from what he identifies as an Aristotelian or hylomorphic model in which creation is the act of giving form to material. Ingold replaces the hylomorphic model with a notion that he calls textility.

My ultimate aim, however, is more radical: with Deleuze and Guattari it is to overthrow the [hylomorphic] model itself and to replace it with an ontology that assigns primacy to the processes of formation as against their final products, and to the flows and transformations of materials as against states of matter. Form, to recall Klee's words, is death; form-giving is life. I want to argue that what Klee said of art is true of skilled practice in general, namely that it is a question not of imposing preconceived forms on inert matter but of intervening in the fields of force and currents of material wherein forms are generated.³⁴

Ingold's ideas about the nature of skilled practice fit very well with many aspects of acupuncture. Unlike Ingold however, my aim is not to use acupuncture to motivate replacing the hylomorphic model with the idea of textility. Rather, my goal is to reveal the copresence of these models in the clinical encounter.

For instance, a reflection of Ingold's distinction appears in Seem's story between the "good American" way of finding points and the approach taken by expert Asian practitioners. Both sides agree that finding points is a crucial skill. The divergence begins because of the insistence on finding them on "real people." For the obedient

³⁴ Ingold, "Textility of making," 92.

Americans, the exercise is one of projecting preconceived forms onto the largely inert matter of the body. For the Asian masters, the exercise involves recognizing that the body of a real person is living material. Finding points on a real person thus involves navigating the “fields of force and currents of material wherein forms are generated” as Ingold puts it. The difference also helps to differentiate between specificity and nonspecificity. Hylomorphic creation resembles specific action. Textility is aligned with nonspecific action since its operation is entirely context-dependent. Both shape the practice of acupuncture in the United States.

How does acupuncture fit into the broader landscape of American medicine?

The emphasis of differences between cultural and national identity in Seem’s story involves not just issues of practical knowledge but of foreignness, adaptation, and belonging. Ever since the renewal of diplomatic relations between the United States and China in 1972 and the subsequent resurgence in its use, American acupuncture has been thought to belong to another time and place. It is often described as an ancient Chinese practice with a correspondingly foreign way of thinking. Many acupuncturists, clinical researchers, social scientists and members of the public imagine American acupuncture as a displaced practice in the process of being translated and adapted into a new setting.

Early evidence of these themes can be seen in a radio interview of John Bonica in October of 1972. Bonica, a world-renowned pioneer in the field of pain management, was then serving as the chair of the National Institutes of Health Ad Hoc Committee on Acupuncture. Riding a wave of enormous public interest, the committee was tasked

with developing a research program to investigate the clinical possibilities of acupuncture.

Bonica: Acupuncture has been used for a large variety of disease states. We felt that we could not become involved with all of these conditions but we limited it to the management of chronic pain because I think that this is a very important national health problem and also because this is an area where patients often seek help and where there might be exploitation of patients by quacks who would purchase a needle and go into the business of treating chronic pain... I want to reemphasize that my own personal view, and I believe that I reflect the view of the committee, is that we believe the reports that are coming out of China that it does work there. What we have to ascertain is how it works, what conditions contribute to the success and whether these same conditions are available here in the United States.

Reporter: And whether it has something to do with a national character or a national tradition?

Bonica: Yes, there are many many issues.

Reporter: Will Americans accept acupuncture is another good question.

Bonica: Right.³⁵

³⁵ Lawrence Dulcie. October 6, 1972. "Dr. John Bonica discusses use of acupuncture."
<https://archive.mpr.org/stories/1972/10/06/dr-john-bonica-discusses-use-acupuncture>.

Throughout the interview, Bonica displayed a conceptually nuanced and historically grounded understanding of acupuncture as it had been practiced in China. He explained that Chinese biomedical physicians and Chinese acupuncturists tended to be distinct groups of practitioners whose perspectives were not reducible to something singularly Chinese. He emphasized that acupuncture in China should be understood not only as an ancient tradition but in the context of the limited resources of the Chinese healthcare system and the politics behind the modernizing programs of Mao Zedong. Bonica knew that much of what appeared to be traditional and Chinese about the images of acupuncture coming out of China was actually innovative, globalized, and already a product of efforts to reimagine what Chinese medicine could be and how it might relate to biomedicine. He saw all of these factors as making up the specific “conditions” of acupuncture practice in China and that these conditions might not have been relevant for practice in the United States. Bonica was also fully aware that chronic pain presented a significant and underappreciated challenge to American healthcare practitioners (a “national health problem”). The successful translation of acupuncture would require understanding conditions in the United States as well as China. Against Bonica’s cautious and multifaceted analysis, the reporter adds the idea of essentialized differences in national character and tradition. The exchange is a wonderful example of the many ways that acupuncture was imagined to be foreign.

In my experience both studying and practicing acupuncture over the years, I have witnessed countless occasions in which acupuncture was framed in terms of national, cultural, or traditional characteristics. For instance, I vividly remember a

conversation that I had with one of my teachers in acupuncture school. I had become close to this particular teacher over my years in school in part because I was one of the only students who had a grasp of the Chinese language and could decipher the intricacies of her accent and way of speaking. I was also one of few students who felt comfortable with her often gruff demeanor. One day, I caught her sitting alone drinking tea in the clinic's common room. I knew that she was supposed to be participating in a master class on pulse taking taught by a well-known American acupuncturist. Seeing an opportunity for the student to chastise the teacher, I sat next to her and asked why she was skipping out on class. She replied simply, "why should I listen to him? He doesn't know anything; he's not Chinese." The response was delivered in the brusque but almost unassuming manner that I could never quite convince myself was a product of my teacher's very dry sense of humor. For her, the American lecturer's inadequacy was not a matter of opinion; it was either a joke or, more likely, an unfortunate matter of fact.

Anthropologists of acupuncture and Chinese medicine have been keen to criticize such stark and static models of cultural difference. They have focused instead on how the various social and material conditions that influence acupuncture use are shaped by the movement, translation, and transformation of Chinese medicine. Mei Zhan examines acupuncture through the concept of translocality.³⁶ Volker Scheid works through the dynamic mobility of a "current of tradition"³⁷ and in the tension between

³⁶ Zhan, *Other-worldly*.

³⁷ Scheid, Volker. 2007. *Currents of tradition in Chinese medicine, 1626-2006*. Eastland Press.

plurality and synthesis.³⁸ Sonya Pritzker frames the practice as a form of “living translation” that embodies and enacts Chinese medicine.³⁹ Linda Barnes uses the concept of acculturation.⁴⁰ Roberta Bivins deploys the notion of cross-cultural contact.⁴¹ These conceptual frameworks share a common interest in the location, displacement, and relocation of Chinese medicine, which has been packaged, translated, and evaluated against other medical systems such as biomedicine, as well as within Chinese medicine, which spans a vast array of practice modalities, social contexts, and historical periods within China. These and other social scientists have contributed to understanding how foreign practices become domesticated and how alternative practices operate in the context of medical pluralism. However, as I discuss in chapters 1, 3, and 5, the explanatory and descriptive power of such approaches is limited especially with respect to the concrete experiences and pragmatic concerns that shape clinical encounters between patients and practitioners. As the dissertation unfolds, I argue that the foreignness of acupuncture has a vital role to play for the expression of disease and the experience of therapy. Specifically, the foreignness of acupuncture provides purchase on estrangements and uncertainties brought on by disease. Medical anthropologists and sociologists have long documented the prevalence of uncertainty brought on by the illness experience and by attempts to identify disease. Because American acupuncture is portrayed as a product of translation, it is always already

³⁸ Scheid, *Chinese medicine in contemporary China*.

³⁹ Pritzker, *Living translation*.

⁴⁰ Barnes, Linda L. 1998. “The psychologizing of Chinese healing practices in the United States.” *Culture, Medicine and Psychiatry* 22 (4): 413–443.

⁴¹ Bivins, Roberta. 2010. *Alternative medicine?: A history*. Oxford University Press.

provisional and imperfect and therefore can more easily accept the uncertainties that accompany disease.

The notion that the foreignness of acupuncture is imbricated with forms of self-estrangement has led me to think of acupuncture as a heterotopic meeting place that, in the context of American culture, is seen as inside yet outside, mysterious yet practical, foreign yet intimate. In the clinical encounter, practitioners and patients collect a diverse range of materials and put them towards a therapeutic project. It is a meeting place in which they can come to terms with themselves, one another, and with the world around them.

The notion of heterotopia that I use expands on Michel Foucault's concept for understanding alternative or "other" spaces.⁴² Foucault gives many models of what he deems heterotopic spaces: liminal ritual spaces, vacation destinations, cemeteries, gardens, museums, and ships on the high seas. His primary example is that of a mirror, which exists as a real object in a real space but also situates an imaginary space of reflection within the real. As Peter Johnson shows, scholars frequently depict heterotopias as spaces of transgression, resistance, and challenge to the ordinary.⁴³ James Faubion, for instance, claims that these 'other spaces' are "always contesting and reversing the mundane monotony of the unmarked emplacements of everyday life."⁴⁴ Stella Bolaki finds the heterotopic quality of medicalized spaces in the way that they

⁴² Foucault, Michel. 1986. "Of other spaces." Translated by Jay Miskowiec. *Diacritics* 16 (1): 22–27.

⁴³ Johnson, Peter. 2006. "Unravelling Foucault's 'Different spaces.'" *History of the Human Sciences* 19 (4): 75–90.

⁴⁴ Faubion, James. 2008. "Heterotopia: An ecology." In *Heterotopia and the City*, edited by Michiel Dehaene and Lieven De Cauter, 31–39. Routledge. 32.

“interrupt the continuity and normality of everyday ordinary space in the same way that illness signals a break or discontinuity with ordinary time.”⁴⁵ Acupuncture too has been described by many scholars as a challenge to biomedical authority. Yet as Johnson argues, heterotopias are not always spaces of resistance in Foucault’s writing. Furthermore and in line with the work of Heidi Sohn⁴⁶ and Sigurd Lax,⁴⁷ Johnson points out that “heterotopia is originally a medical term referring to a particular tissue that develops at a place other than is usual. The tissue is not diseased or particularly dangerous but merely placed elsewhere, a dislocation.”⁴⁸ Acupuncture is, likewise, a practice deemed out of place but not out of the ordinary. I describe it not as a practice apart from biomedicine but as an “other” space within biomedicine. American acupuncture reflects the space of biomedicine as much as it represents the displacement of Chinese medicine.

For the purposes of this dissertation, I propose thinking about heterotopia through the example of cavitation (i.e. the formation of air bubbles in a liquid). Cavitation is a displacement that comes about not because gas has been inserted into a liquid from the outside but because conditions (such as pressure, temperature, or rapid changes in flow instigated by movement around an object like a rock or the fin of a propellor) displace air out of solution and into self-organizing bubbles. Understanding

⁴⁵ Bolaki, Stella. 2015. “Heterotopias of illness.” In *The Globalization of Space: Foucault and Heterotopia*, edited by Mariangela Palladino and John Miller, 81–93. 81.

⁴⁶ Sohn, Heidi. 2008. “Heterotopia: Anamnesis of a medical term.” In *Heterotopia and the City*, edited by Michiel Dehaene and Lieven De Cauter, 41–50. Routledge.

⁴⁷ Lax, Sigurd. 1998. “Heterotopia from a biological and medical point of view,” In *Other Spaces*, edited by Roland Ritter and Bernd Knaller-Vlay, 114–23. Haus der Architektur.

⁴⁸ Johnson, “Unravelling Foucault’s ‘different spaces,’” 77.

cavitation involves not just the difference between air and liquid but also the bubble as a particular form. A bubble can be seen as resisting the medium around it but can also be understood as an aspect of the liquid that becomes realized only through the conditions of that very medium.

The cavitation analogy can only go so far of course. A fuller picture can only be achieved when combined with images of translation. American acupuncture mutually entangles the foreignness of ancient East Asia and more intimate conditions that bubble out of modern American life. In this vein, my work speaks to a broader anthropological interest in what Naveeda Khan calls a “foreignness within.”⁴⁹ One of the clearer examples of how this concept applies in the context of healing can be seen in Carla Bellamy’s ethnography of Muslim saint shrines in northwestern India.⁵⁰ Bellamy shows that though these shrines participate in Muslim culture their authority is also attributable to the actions and sentiments of non-muslims who see Islam as a foreign entity within a majority Hindu culture. She claims that the “sources of legitimacy of [the shrine’s] objects, themes, and stories, as well as their means of introduction and transmission... do not derive exclusively (or in some cases at all) from Islamic precedents.”⁵¹ Bellamy shows that “for women in particular, because Muslim saint shrines are removed from the close relationship between religions and family life that exists in the Hindu tradition, they became attractive venues for healing when aspects of

⁴⁹ Khan, Naveeda. 2010. *Beyond crisis: Re-evaluating Pakistan*. Routledge.

⁵⁰ Bellamy, Carla. 2011. *The powerful ephemeral: Everyday healing in an ambiguously Islamic place*. University of California Press.

⁵¹ Bellamy, *The powerful ephemeral*, 14.

the pilgrim's illness are linked to broken family relationships."⁵² To enter these shrines is to step more deeply into problems within Hindu identity by stepping out of them. The movements that take place in these heterotopic spaces appear paradoxical only to those who are committed to a rigid dichotomy between the purity of insides and the heterogeneity of outsides. To avoid falling into such paradoxes, I pose the question as one of embeddedness instead of location.

Finally, I should point out that this image of acupuncture as a heterotopic meeting place supports the idea of creativity as developed earlier. As Liep notes, creativity has classically been seen as a "phenomenon of 'cultural contact'"⁵³ that is strongest at the border or overlap between different cultures. He argues against this assumption because it is premised on the idea of a culture as a "bounded and integrated system of shared meanings and values" rather than an "open and complex system, [which] involves much more inconsistency in the field, and thus allows for creative activity to emerge at many points."⁵⁴ The model of cavitation shows how these two ways of thinking about culture are not mutually exclusive. Heterotopic meeting places are openings from the inside to a different aspect of the inside.

Methods

In this section, I walk through methodological aspects of cultivation as they pertain to

⁵² Ibid, 15.

⁵³ Liep, *Locating cultural creativity*, 7.

⁵⁴ Ibid, 7.

fieldwork and archival research. When I say that my ethnography cultivates a field of inquiry, I have an idea of cultivation in mind that comes out of a particular set of methods and processes. These include forms of participant-observation and interviewing that make up my fieldwork, archival research that traces the genealogy of acupuncture's concepts and practices, forms of writing that develop these ideas together, and methods of examination and analysis as situated within a particular lineage of anthropology.

Fieldwork

Having studied and practiced acupuncture for a decade before entering into graduate school for anthropology, there is a sense in which I am a native anthropologist of American acupuncture. Certainly, there were times during fieldwork when the perceptive and analytic regimes of acupuncture and anthropology melded together. With this in mind, I divide the fieldwork for this dissertation between a period of *immersive* fieldwork prior to my academic training in which I experienced acupuncture primarily as an acupuncturist and a period of *formal* fieldwork in which my experience of acupuncture was mediated through anthropological concepts and ethnographic practices such as observation, interviewing, and note-taking.

My path to becoming an acupuncturist began in the late 1990s when I was a regular practitioner of both Chinese martial arts and Zen meditation. In the course of these practices, I ran repeatedly into acupuncturists who seemed to have access to a technical language for talking about what were otherwise strange and ineffable

experiences. As I got to know these acupuncturists better, I became fascinated with the simplicity and effectiveness of their work and decided to pursue it as a profession. I recall those days as being filled with a joy of discovery that was both the finding of something new and the uncovering of something that was already there. Acupuncture was, for me at that time, a constellation of embodied feelings to which terms and concepts were only just being attached. This route into acupuncture has undoubtedly influenced both later fieldwork and analysis.

From 2000 to 2003, I attended the Oregon College of Oriental Medicine (OCOM). My education there was a mix of abstract ideas and hands-on skill-building. I studied concepts such as the applications of yin-yang theory, the names and indications of items in the Chinese materia medica, aspects of the vast Chinese medical formulary, the locations and uses of the meridian system. I also learned a great deal about Western medicine as well. I say “Western” medicine as opposed to biomedicine because all of my classes on Western medical principles and practice were taught by naturopaths whose medical philosophy does not completely coincide with biomedicine. OCOM is in an interesting position with respect to health education because in Oregon naturopaths can work as primary care providers. This is not to say that the subject matter of the Western medical classes taught at OCOM was unusual. There was, however, a common understanding that the contemporary approaches of biological science, though incredibly useful and highly informative, was not the only game in town when it came to even western medical clinical reasoning.

In studying acupuncture, I also developed much more than medical knowledge

and clinical skills. I was in my early 20s when I first started at OCOM and had only been a year or so out of college. I was learning to become a professional adult.

Acupuncture was a second career for a large number of my classmates, many of whom were already nurses or massage therapists. In my clinical rotations, I regularly had new appointments with patients who were 40 or more years my senior and in serious physical or mental anguish. Almost every day, I had to confront the pain and suffering of strangers through acupuncture. This was an entirely new social situation that I had to learn to navigate. I have carried a heightened awareness of these social aspects of practices into this dissertation.

After graduating from OCOM, I began practicing acupuncture, first in a private practice in Philadelphia, then as an employee within a larger integrated practice in East Lansing, Michigan, and later in a clinic in Virginia. Although none of my experiences during this time are explicitly described in this dissertation, the skills that I honed during this period were formative for later fieldwork. Having treated thousands of patients, I became increasingly cognizant of what could be both perceived and achieved in the clinical encounter—how informative a pulse could be, how quickly acupuncture can work but also how slippery its effects can be, how seeming different symptoms can be tied together, and how resistant they can be to treatment. For the first three years of graduate school, I continued to work as an acupuncturist. During my early fieldwork, the proximity in my mind and body of these two very different disciplines caused them to blend even as I tried to hold them apart. In my first semester, for example, I was taking four classes in Baltimore while treating patients two days a week in Virginia. My

schedule was such that I had to talk to some patients over the phone between classes. On occasions when a patient did not show up for an appointment, I did readings for classes in the treatment room. I could not help but think through the concerns of patients and the problems of anthropology together.

My first formal fieldwork period took place over the summer of 2011. The summer was split between two acupuncture clinics on the East coast and two on the West coast. During this time, I focused my research on acupuncturists. I recruited 13 of them into the study. I shadowed them in their practices and interviewed them on a variety of subjects. I had known some of these practitioners from my time in acupuncture school. Others I had met in continuing education classes or in the context of professional organizations. I also recruited several practitioners from outside of my professional network. Most were eager to be a part of my research although many had reservations about how useful they would be as research subjects (as I will describe in chapter 1). Overall, I was able to enter into the social and professional networks of other acupuncturists without too much trouble.

Developing an anthropological approach to acupuncture was a much more significant challenge. I was ready to trust my judgment as an acupuncturist but still needed to find my feet as an anthropologist. One of the biggest dangers of relying too heavily on personal clinical experience was the potential of seeing other practices only through habits of practice that I had built for myself. In order to offset this possibility, I included six different acupuncture clinics and 14 acupuncturists in my fieldwork and tried to get a sense of how each practice was different from the others (I describe aspects

of two clinical spaces in detail in chapter 3). I also made a conscious effort to shed assumptions about what acupuncture was doing or how it was working. The effort to reorient my disposition towards acupuncture was part of what moved the question of what kind of activity acupuncture is to the center of my research.

I also made a point of asking my interlocutors, ‘if you were in my place and had a chance to observe other acupuncturists, what kinds of things would you want to investigate?’ Practitioners came up with many intriguing questions, most of which have been absent from most ethnographies of Chinese medicine. Acupuncturists were interested in the business models of other clinics, the kinds of interpersonal skills and personal qualities that make acupuncturists successful, and the patterns of acupuncture use among different patient populations. These questions encouraged me to shift my research towards the interpersonal and creative aspects of the clinical encounter.

In the spring and summer of 2013, I did a second round of fieldwork in which I revisited an acupuncture clinic and observed its acupuncturists. I expanded my observation of clinical spaces to include a number of objects and materials that were not therapeutically specific to acupuncture (as I will explore in chapter 3) as well as interpersonal relationships such as those involving clinical staff and occurring between patients. I also began to play with different ways of noting clinical activities such as documenting the dynamic movement of people in the clinic in the form of flowcharts, depicting and recording clinical soundscapes, and photographing and drawing objects of interest. Many of these methodologies of observation do not appear directly in the text of this dissertation but they affect the writing nonetheless.

I spent much of my time in clinics following acupuncturists in a manner that I had been accustomed to when shadowing practitioners during my time as an intern in acupuncture school. The rest of my time was divided between observing clinical activities as if I were a patient, shadowing patients directly, interacting with clinic staff, and observing the layout of the clinics and their surrounding neighborhoods. Taking on the perspective of patients, I would lay on spare treatment tables, relax in treatment chairs, or sit in waiting areas. I followed clinical staff through their day-to-day tasks and tried to learn to perform them myself.

In 2014, I did my longest stretch of continuous fieldwork, returning to an acupuncture clinic and visiting two new ones. It was during this period that I focused much more significantly on spending time with acupuncture patients. I recruited these patients through the clinics by posting signs inviting them to participate. Many recognized me from previous stints of fieldwork. When working with a new patient participant, I would always interview them first to make sure that they would be comfortable with me following them for some of their treatments. With around 20 patients, I did a series of two or three interviews. Six patient-participants whose cases had become important for my research and with whom I spent a significant amount of time authorized me to review their medical charts as kept by their acupuncturist. In chapter 4, I present two patient cases, one of which includes the analysis of a medical chart.

The first round of interviews that I conducted with patients or practitioners were always semi-formal semi-structured affairs. I usually arranged to meet the interviewee

for lunch or coffee. With the participant's permission, these interviews were recorded and I took notes as well. I tried to develop these interviews around open-ended questions. I would ask patients: What has been your experience of acupuncture? Why did you start doing it? What do you get out of it? For practitioners, I would ask what drew them to practicing acupuncture, how they think it works, and what their practice is like. Most people did not need much encouragement and interviews could span two hours without any encouragement from me.

Between 2015 and 2018, I continued to conduct fieldwork infrequently but consistently. I would revisit clinics for a day or so to say hello and catch up on news. I talked to patients or practitioners by phone or email on occasion. My ability to keep in touch with my interlocutors over time has been especially helpful in the writing of chapter 4 in which I follow patient cases based on repeated interviews and conversations across many years.

Archival research

The archival research methods of this dissertation have evolved significantly over time. Originally, my historical methods were meant to illustrate the contemporary conditions of acupuncture's acceptance today by comparing it with the rise and decline of acupuncture in earlier periods of American history. Acupuncture was very popular during the 1820s and was promoted throughout the nineteenth century by a number of physicians including none other than William Osler. Yet, by the second decade of the twentieth century, acupuncture had been largely resigned to a historical curiosity. I

wondered why acupuncture, after rising to prominence again in the 1970s, had not risen and declined in the manner seen in earlier periods.

Because global histories of acupuncture and Chinese medicine such as those by Linda Barnes,⁵⁵ Bivins,^{56,57} and Harold Cook⁵⁸ frame the movement of techniques and ideas as a matter of crossing cultures, I assumed that a similar framework would apply in the United States. When I began to read through nineteenth-century American texts however, I found that acupuncture was only rarely framed as a cultural practice. Most considered it to be a form of surgery. The Chinese and Japanese history of acupuncture was occasionally mentioned but was seldom deemed relevant enough to explore. Wondering when and how the Chinese identity of acupuncture had come to the fore, I sought out further primary source material. I began by reading through dissertations that include historical accounts of acupuncture in the United States such as Bowen,⁵⁹ Chow,⁶⁰ Devitt,⁶¹ Geiser,⁶² Hare,⁶³ and Heffner⁶⁴ and pulled relevant primary and

⁵⁵ Barnes, Linda. 2009. *Needles, herbs, gods, and ghosts: China, healing, and the West to 1848*. Harvard University Press.

⁵⁶ Bivins, *Alternative medicine?*.

⁵⁷ Bivins, Roberta. 2000. *Acupuncture, expertise and cross-cultural medicine*. Springer.

⁵⁸ Cook, Harold. 2007. *Matters of exchange: Commerce, medicine, and science in the Dutch golden age*. Yale University Press.

⁵⁹ Bowen, William. 1993. "The Americanization of Chinese medicine: A discourse-based study of culture-driven medical change." PhD Diss., University of California, Riverside.

⁶⁰ Chow, Effie Poy Yew. 1975. "Acupuncture: Its history and educational significance to health practices in the United States." PhD Diss., The Fielding Institute.

⁶¹ Devitt, Michael. 2014. "From remedy highly esteemed to barbarous practice: The rise and fall of acupuncture in nineteenth-century America." Master's thesis, University of Missouri-Kansas City.

⁶² Geiser, Christine Robin. 1989. "Acupuncture in Florida: History, regulation, and policy." PhD Diss., University of South Florida.

⁶³ Hare, Martha. 1991. "East Asian medicine among non-Asian New Yorkers: A study in transformation and translation." PhD Diss., New School for Social Research.

⁶⁴ Heffner, Sarah. 2012. "Investigating the intersection of Chinese and Euro-American healthcare practices in Nevada from 1860-1930." PhD Diss., University of Nevada, Reno.

secondary sources. When I came across Dorothy Rosenberg's dissertation,⁶⁵ I felt like I had found a road map for the historical processes that have resulted in acupuncture being thought of as a modality of Chinese medicine. Researched and written between 1973 and 1977, Rosenberg's work included both historical inquiry and surveys of medical interest in acupuncture at the time. Reflecting the uncertain status of acupuncture, Rosenberg had tried to comprehend the then open question of how acupuncture would be recognized, classified, and either incorporated or rejected by medical institutions. She approached acupuncture not as a practice to be translated from one culture into another but as an innovation whose terms of acceptance into the United States were not yet known.

Taking up a genealogical approach, I collected historical materials from digital databases⁶⁶ and collections of medical journals and textbooks, congressional and legal records, nineteenth-century newspapers, periodicals, and literature. The proliferation of digital archives over the past decade has vastly increased scholarly reach in exploring the historical texts of American medicine. Rosenberg, whose history of acupuncture in the United States is both accurate and thorough relied primarily on hand collated bibliographies such as the Index Medicus to sift through the vast medical literature. Bowen, whose analysis of Chinese medical advertisements in American newspapers is excellent, used similar library indexes to uncover his material. These indexes captured

⁶⁵ Rosenberg, Dorothy. 1977. "Acupuncture and U.S. medicine: A socio-historical study of the response to the availability of knowledge." PhD Diss., University of Pittsburgh.

⁶⁶ Key databases include the Hathitrust Digital Library, Chronicling America Historic American Newspapers, Newsbank, the Digital Congressional Archives at the Library of Congress, the 19th century index, and Proquest historical newspapers.

text about acupuncture but often missed texts that only mention acupuncture such as surgical manuals. Such texts have been essential in my attempt to flesh out the larger context of how acupuncture has been classified in the United States at different historical moments. They were especially useful towards understanding how and when notions of acupuncture's Asian history entered into the terms of classification.

I spent a significant amount of time rooting through folders in physical archives as well. A fortuitous conversation with the historian Keith Wailoo led me to several collections stored in the special collections at UCLA. While there I explored John Bonica's collected papers, the archives of the American Academy of Pain Management, and the Elmer Belt Manuscript collection, each of which provided an incredible window onto the medical reception of acupuncture in the 1970s.

Chapter summary

Each chapter of this dissertation could each stand on their own in terms of content and argument.

Chapter 1 – Not-knowing: The first chapter introduces American acupuncture by considering the ways in which patients and practitioners reject knowledge about the practice. I use the hyphenated term “not-knowing” to indicate that what I am talking about is not a form of ignorance but is instead a way of emphasizing those aspects of acupuncture therapy that are not beholden to knowledge. I describe how different

acupuncturists claim that the need to know can blunt the therapeutic force of acupuncture whereas not-knowing can enhance perceptual awareness. I also show how patients describe feeling pressure to know as much as they can about biomedical treatments but no comparable obligation to pursue knowledge about acupuncture.

The chapter describes three different ways in which knowing can be understood in acupuncture. First, we can think about knowing as a set of abstract principles of practice, a set of specific empirical findings, and the ways in which practitioners coordinate these two sets in order to perform therapeutic actions. When acupuncture employs this kind of knowing it can be seen as disenchanted in the Weberian sense: i.e. it is the application of specialized technical knowledge (*Fachwissen*) whose principles are both impersonal and instrumental (*Zweckrational*). Second, we can see knowing as embedded in cultural and social conditions rather than abstract and impersonal structures. The tension between these two notions of knowledge (instrumental rationality and a more culturally and socially situated approach) has been an important site of investigation within medical anthropology and for ethnographies of Chinese medicine, which have leveraged these differences to both expand and critique what it means for anthropologists to study medical epistemologies. Because the chapter focuses on claims to not-knowing, it ultimately suggests a third way of thinking about knowledge, one that is indebted to the work of J. L. Austin and Stanley Cavell. These philosophers describing knowing as a stance towards the world rather than an account of it. Their notion of knowing describes it as a claim directed towards others rather than a relation between the knower and an object of knowledge. This concept of knowing is

not just social situated but is inherently social. I use this concept of knowing to suggest that expressions of not-knowing are directed towards developing therapeutic relationships between patients and practitioners. I also suggest that the prevalence of not-knowing in acupuncture can be tied to the nonspecific aspects of its efficacy.

Chapter 2 – The 19th Century: The second chapter is a genealogy of acupuncture in the United States in the nineteenth century. It analyzes texts drawn from medical journals, textbooks, newspaper articles, and literary sources. The chapter is divided into three sections. The first section covers the historical period from the intense interest in acupuncture in the 1820s until just before the rise and consolidation of American medical institutions in the 1850s. At that time, acupuncture was often portrayed as a European medical innovation associated with either French anatomists or British empiricists. Some medical sources classed acupuncture as a simple form of surgery whose mechanisms could be thought of in terms of fluid mechanics, counter-irritation, electrical phenomenon in the body (galvanism), or nervous system physiology. Others saw acupuncture as a component of a practical medicine that is “essentially empirical... [and prejudiced] against all attempts to append theory to the deductions of mere experience.”⁶⁷

The last two sections of the chapter show how the place of acupuncture was transformed in the latter half of the nineteenth century and the beginning of the twentieth. The second section describes how acupuncture became marginalized along

⁶⁷ Forbes, John, Alexander Tweedie, and John Conolly, eds. 1832. *The cyclopaedia of practical medicine: Vol 1 ABD - ELE*. London. 2.

with other forms of practical medicine that did not fit the increased emphasis on standardized, institutionalized, and centralized medical practice. The historian Charles Rosenberg has described this transformation in American medicine as a shift away from the complex emotionally and spiritually charged interventions of a home-based practice towards a formally recognized system of knowledge situated in “the physician's office or some institutional setting.”⁶⁸ For the itinerant doctors of the nineteenth century, the ideal treatments were those that produced “phenomena which all—the physician, the patient, and the patient's family—could witness (again, the double meaning, with its theological overtones, is instructive) and in which all could participate.”⁶⁹ Acupuncture, with its relatively safe operation and obvious and immediate effects, fit this bill quite well. The practice does not, however, operate in a way that research can easily specify or with knowledge that can easily be standardized.

The third section delves into the sudden and intense encounter with Asia that occurred in the American late nineteenth-century. It explores a time when China and Japan had both been “opened” to American trade and missionary work: China in the wake of the First Opium War (1839-1842) and Japan as a result of Commodore Perry's Expeditions (1852-1854). Not only were Americans now traveling to Asia but the Chinese were also immigrating to the United States in significant and unprecedented numbers. The 1850s saw the number of Chinese in America jump from the hundreds to the tens of thousands. By the time of the Chinese Exclusion Act of 1882, acupuncture

⁶⁸ Rosenberg, Charles. 1992. *Explaining epidemics and other studies in the history of medicine*. Cambridge University Press. 30.

⁶⁹ Rosenberg, *Explaining epidemics*, 15.

was caught up in the struggle between those expressing anti-Asian sentiment and others who saw China as a new frontier to be explored. The former group described acupuncture as a barbarous superstition and the latter saw it as a strange practice but one worthy of serious study.

Chapter 3 – Clinical spaces: The third chapter examines clinical spaces and the objects in them by looking at two clinics in which I did fieldwork, Clinton Street Acupuncture and Green Leaf Community Acupuncture. The chapter demonstrates a need to broaden social scientific understanding of how space and material can be incorporated into therapy. Anthropologists such as Kevin Taylor Anderson have described objects and spaces in terms of an aesthetic meant to associate acupuncture with the legitimacy of biomedicine while at the same time differentiating it from biomedical ideology.⁷⁰ Against this idea, the chapter argues that the practitioners of Clinton Street and Green Leaf see these materials and spaces not as a means to control impressions of acupuncture but as potential openings to transformation and reorganization. The meaning of objects and spaces is purposely held open for new possibilities of interpretation to emerge.

To draw out the difference between spaces designed to control and those that engender emergent properties, I turn to the notion of poetics in Heidegger's distinction between technological interventions which "set upon" objects and poetic processes which "bring forth." Bachelard's investigation of the poetics of space further develops

⁷⁰ Anderson, Kevin Taylor. 2010. "Holistic medicine not 'torture': Performing acupuncture in Galway, Ireland." *Medical Anthropology* 29 (3): 253–277.

these ideas by showing how poetics works not through the accumulation of a history of meaning but through echoes and reverberations that coalesce in a moment. I show how these theories of poetics correspond with the experiences of patients and practitioners and my own descriptions of objects and spaces. My ethnography lingers on objects such as an arrangement of flowers, a stone statue, and a collection of images hanging on the wall of a particular treatment room.

Chapter 4 – Diagnostic terms: This chapter is organized around two patient cases that are composed of interviews, clinical observations, and medical records. It argues that, when seen through the experiences of a patient, diagnostic terms are dynamic and take on emergent features. Such emergent properties tend to go overlooked when diagnosis is thought of as a way of labeling or recognizing a disease state according to the criteria of a medical system of knowledge.

The first case follows Alice as she makes decisions about her use of acupuncture while navigating a “cancer scare,” in which a nodule is detected in her lungs. The second case explores how acupuncture becomes a venue through which Jennifer comes to recognize, express, and begin to recover from conditions of abuse and trauma. With these cases, the chapter shows how American acupuncture cultivates the emergent features of diagnostic terms in order to better respond to the lives of patients. I suggest that some patients find the open-ended nature of acupuncture therapy effective because it reflects their own struggle between the uniqueness and sharedness of their illness experience. My argument in this chapter pushes against critical theorists and medical anthropologists who tend to assume that the experience of suffering is undeniably

apparent for the one suffering yet impossible to adequately communicate to others

Chapter 5 – The 20th century: This chapter explores the rise of acupuncture in the 1970s by looking at the circumstances in both China and the United States in the early twentieth century, and then by examining how organizations within American biomedicine, legal institutions, and popular movements each positioned their understandings of acupuncture. The chapter draws on material from articles in medical journals, newspapers and magazines, historical accounts, travel reports, conference proceedings, legal documents, and personal correspondences. These materials give a sense of the diversity of ways of thinking about acupuncture both in the United States and in China. I go on to show how these differences largely dissolved by the late twentieth century. After attempts to ground the practice in biomedical principles had stalled, the idea that acupuncture was a practice based on the culturally specific principles of Chinese medicine became widespread. Thus, the chapter argues that the association between acupuncture Chinese medicine is itself contingent on a complex set of historical circumstances involving different medical and political factions in the United States and China.

Dissertation overview

Although each chapter contains its own argument, they also build on each other in specific ways designed to help the reader navigate the material. The first two chapters

challenge existing assumptions about acupuncture. These chapters summarize aspects of contemporary social scientific research on acupuncture while also pointing out limitations that suggest the need for a new approach. The first chapter critiques the commonly held idea that acupuncture is premised on a “way of knowing” that, though different from knowing as it is found in biomedicine, is nonetheless foundational to the practice. The second chapter confronts the related idea that the history of American acupuncture is the history of a displaced practice being translated into a new cultural context. Together these chapters function to rethink anthropological approaches to acupuncture in the first case by replacing questions of knowledge with attention to processes of perception and awareness and in the second case by telling a history of how acupuncture has been classified as a form of practical medicine rather than East Asian medicine.

The third and fourth chapter further ground the arguments of the first two by focusing on the concrete, material, and spatial components of contemporary practice in chapter 3 and the experiential and embodied aspects of illness and therapy in chapter 4. Chapter three frames the therapeutic practice of acupuncture through its clinical spaces and objects by using the concept of poetics. Chapter four explores the cases of two acupuncture cases to show how their experience of acupuncture is expressed through emergent diagnostic categories. Together these two chapters develop an approach to the creative aspects of acupuncture as they occur in and around the clinical encounter.

The fifth chapter can be seen as the culmination of the arguments laid out in earlier chapters. Where the first two chapters show how acupuncture *need not* be

understood as a culturally inflected practice based in Chinese medical knowledge, this chapter tries to show how and why acupuncture *has come to be* understood in precisely this way. There is a paradox at the heart of American acupuncture that, though difficult to see, is vital to its acceptance and proliferation: in order to adapt to conditions in the United States, acupuncture has become more rather than less foreign.

Chapter 1

The less I know, in fact, the better:

Not-knowing in American acupuncture

But how do we stop? How do we learn that what we need is not more knowledge but the willingness to forgo knowing? For this sounds to us as though we are being asked to abandon reason for irrationality (for we know what these are and we know these are alternatives), or to trade knowledge for superstition (for we know when conviction is the one and when it is the other - the thing the superstitious always take for granted). This is why we think skepticism must mean that we cannot know the world exists, and hence that perhaps there isn't one (a conclusion some profess to admire and others to fear). Whereas what skepticism suggests is that since we cannot know the world exists, its presentness to us cannot be a function of knowing.¹

Although acupuncture has had a place within the system of medical professions in the United States for more than 30 years, there has been no consensus over how to explain its efficacy. The problem is not one of lack. A diverse range of concepts from the scientific to the spiritual, from ideas associated with East Asian cultures to simple practicality are used to explain acupuncture and why people use it. Theories of endorphin release, gate control theories of nervous impulses, anatomical maps of

¹ Cavell, Stanley. 1976. *Must we mean what we say: A book of essays*. Cambridge University Press. 324.

trigger point phenomenon, and physiological findings of electrical conductivity in connective tissue have been used within the research community. In clinical practice, more naturalistic theories include those concerning human energetics, meridian systems, and microcosmic correspondences. Some acupuncturists ascribe to psychological notions of placebo and mind-body connections. Even within Chinese medicine, very different ideas of acupuncture circulate. Concepts from Yijing divination to depictions of the body as a civil bureaucracy, a habitat for demons, a burial ground of ancestral spirits, or a revolutionary battleground make up very different Chinese medical frameworks for acupuncture.

When I first began formal fieldwork in 2011, my aim was to uncover the diverse range of therapeutic repertoires used within acupuncture and to explore the social conditions through which these repertoires took shape. I was especially focused on how acupuncturists navigate an epistemological divide that has existed since the 1970s. On one side, the regulatory, pedagogical, and formal discursive institutions of American acupuncture aspire to standardize acupuncture knowledge. Acupuncture schools, national accreditation organizations, state regulatory boards, and medical journals of acupuncture and Chinese medicine have invested considerable effort into making acupuncture knowledge stable and recognizable. On the other side, clinical practitioners have been skeptical of this process. Many acupuncturists, especially those with extensive clinical experience, have argued that effective therapeutic activity requires the kind of hermeneutic openness that occurs when very different and even incongruous epistemic fields are available for reinterpretation in the context of clinical

practice.

Attempting to describe how each acupuncturist's unique constellation of knowledge took shape in and against the forces of standardization, I began to observe their practices and ask them about their images of the body, logics of therapeutic action, and clinical techniques. Almost immediately, however, I faced reluctance on the part of acupuncturists to claim knowledge of even a singular nature. Practitioners could speak of their models of acupuncture or of the body but almost always with the caveat that their explanations were inadequate and their images hazy. My interlocutors emphasized that their understanding did not constitute definitive knowledge or sometimes even knowledge at all.

Lara was one such practitioner. When I first interviewed her, she had been an acupuncturist for five years, had worked in a number of clinics, and was starting to feel comfortable with what she saw as her style of practice. When I asked her to describe the conceptual models that she relied on to shape her use of acupuncture, she spoke first of a "Chinese" model for the meridians, which drew on the analogy of "a water system of canals and rivers and streams." Then, she added that she also has "a little bit of a Western feeling about it" that entails understanding how "fascia conducts piezoelectricity through pretty standard pathways."

When I asked how these two models fit together, Lara gave conflicting responses. At first, she privileged the Eastern model saying that she hadn't found anything better than its "metaphor of water and qi." Soon after, she reversed herself saying that she was instead "leaning towards this fascial [Western] picture." Then later,

she claimed to “flip” between one and the other. At one point, she even described them as compatible because water and electricity are both manifestations of the concept of flow.

As I paused trying to sort out these various positions for myself, Lara broke with my line of questioning. The break began almost as an aside but within moments had shifted the topic of conversation from one of epistemological diversity to a respect for the unknown and its therapeutic possibilities.

Lara: I mean, everybody’s tried to explain meridians and [these are the models that have] kind of resonated the most with me. But, at the same time, you know, I’m actually happy not knowing *exactly* what they are. It is a bit of a mystery and I’m—I’m okay with it.

Victor: What about *that* appeals to you? I’m just kind of curious. You may not know. I mean, is it just kind of an innate appeal that it doesn’t have a specific scientifically explainable function?

Lara: For me, it fits more with—with how things are as a whole. There’s a lot of unexplained things in the universe. And, we can’t know everything and that keeps us kind of curious and maybe more open in some ways. The mystery is not solved. So, you keep wondering and thinking and chewing on it. This to me is a more dynamic interesting process than some sort of *end*-point. I don’t have that kind of mind that needs to do that. I feel like, you know, abandoning control over everything is the way to go. So, the less I know, in

fact, the better.

[laughter]

Victor: It's interesting because that's very different from this kind of standard biomedical approach which is: not understanding the function or the exact mechanism of some type of medical object, whether it's a therapy or disease process, is a deficiency in the model.

Lara: Right. I know.

Victor: But, this is something that you see as being almost essential to practice?

Lara: I mean, in a research paper, it would be not so great but, in terms of practice, I think it's—it's absolutely important for both the patient and the practitioner. Especially in this society where we have this scientific model that's so tightly controlled. I see that being a problem for people in general. That type of thinking, that rigid thinking, can lead them into illness.

Victor: So, it's both bad practice and a source of illness?

Lara: Rigid thinking?

Victor: Yeah.

Lara: In excess, obviously. There's nothing wrong with wanting to scientifically prove something but there is something wrong with not being open to the fact that you may not be able to know.

The less I know, in fact, the better. Lara spoke the words boldly, knowing how easy it would have been for me to object. Earlier negotiation between Eastern and Western

models was now set aside.

Lara's statement captured an approach to practice whose refrain I had been hearing in the words of many acupuncturists. In fact, their claims to not-know had been frustrating me. Many had even excused themselves from participating in my research because they did not rank themselves knowledgeable enough to make fit subjects. When discussing my recruitment problems with a friend and fellow acupuncturist, he quipped, "that's the big secret: none of us actually *knows* anything. *That's* why no one wants to talk to you." For a time, I believed that if I could just find the right way to validate each acupuncturist's perspective, they would feel empowered enough to share their personal forms of knowledge. Yet, I could not shake the feeling that introducing my research as investigating the practitioner knowledge had constrained rather than invited elaboration. When asked about knowledge of acupuncture, acupuncturists often hesitated as if any answer risked being wrong.

Adjusting my approach, I began to frame my work as unsettling the otherwise convivial bond between expertise and knowledge. Is knowing a foundational component of skill and if not what kind of relation is it? Acupuncturists became noticeably more responsive to these types of questions. Simply raising the possibility that therapy could be based on something other than knowledge would cause faces to light up and voices to come to life. Their enthusiasm encouraged me to set the assumption of knowledge aside. I have come to think of this setting aside as "not-knowing," a term that indicates not an ignorance or lack of ability but the conviction to apprehend and act in the world in a way that does not depend on

knowing. In the wake of Lara's suggestion that not-knowing would not be a good topic for a research paper, I have had a dawning appreciation for how difficult it is to bring therapeutic not-knowing into academic writing.

One of the immediate challenges for describing the value of not-knowing is the extent to which the acupuncture profession is tied to it having a particular body of knowledge. The model under which healthcare practices in the United States today are legally legitimized assumes that the medical actions of practitioners are rooted in a body of technical knowledge. The governing principles of the system of medical professions are built around an ethic of vocation classically described by Max Weber as rationalized, intellectualized, and ascetic. In his summary of Weber's argument, Rogers Brubaker states that the "growing complexity of the technical and economic base of social life [in Western societies], together with the inexorable advance of bureaucracy, fuels an ever-growing demand for specialized technical knowledge (*Fachwissen*)."² In order to operate in conjunction with contemporary state and market power, the work of medical professionals is framed as impersonal and instrumental (what Weber might call *Zweckrational*). Participation is however not without cost. The price of admission is what Weber calls disenchantment.

Does [scientific progress] mean that we, today, for instance, everyone sitting in this hall, have a greater knowledge of the conditions of life under which we exist

² Brubaker, Rogers. (1984). *The limits of rationality: An essay on the social and moral thought of Max Weber*. Routledge. 31.

than has an American Indian or a Hottentot? Hardly... The savage knows incomparably more about his tools... [No,] it means something else, namely, the knowledge or belief that if one but wished one could learn it at any time. Hence, it means that principally there are no mysterious incalculable forces that come into play, but rather that one can, in principle, master all things by calculation. This means that the world is disenchanted. One need no longer have recourse to magical means in order to master or implore the spirits, as did the savage, for whom such mysterious powers existed. Technical means and calculations perform the service.³

If properly disenchanted, medical expertise can also aspire to become a matter of calculation that anyone could learn to perform if they so desired. The logic of disenchanted medicine must, therefore, be as explicit and broadly accessible as possible. The “mysterious incalculable forces” that once could be drawn on to explain disease and guide treatment are then replaced with uncertainties. Scholars such as Renee Fox⁴ and Paul Atkinson⁵ have made clear that, though the experience of illness is pervaded by the unknown, rational medicine can have nothing but utter disdain for these uncertainties. In this chapter, I make the case that it is within this field of contention, between institutions that demand complete knowledge and the sense of mystery that surrounds the illness experience that not-knowing in acupuncture takes shape.

³ Weber, Max. 2013. *From Max Weber: Essays in sociology*. Oxford University Press. 139.

⁴ Fox, Renee C., R. K. Merton, G. Reader, and P. L. Kendall. 1969. *The student-physician: Introductory studies in the sociology of medical education*. Harvard University Press.

⁵ Atkinson, Paul. 1984. “Training for certainty.” *Social Science & Medicine*, 19(9), 949–956.

Acupuncture is at once part of a system of professions bound to present its actions as rationalistic (i.e. without mysterious or incalculable forces) while at the same time a practice whose therapeutic effect draws on unknowns not tolerated in other regions of American medicine.

In the first section of this chapter, I follow practitioners like Lara who claim that knowing can blunt the therapeutic force of acupuncture. I explore statements found in interviews I conducted with practitioners and patients while also grounding their claims in clinical experiences. In the second part of the chapter, I situate my argument with respect to other ethnographies of acupuncture and Chinese medicine. I show how, in this body of literature, problems of knowledge are tied to differences in forms of knowledge and ways of knowing rather than residing within the difference between knowing and not-knowing.⁶ I argue that the image of acupuncture as a learned profession can be tied to not only the rise of acupuncture as a profession in the United States but the emergence of medical anthropology and science studies as sub-disciplines as well. Seeking new grounds on which acupuncture and anthropology can come to terms, the third section explores skepticism of the sort invited by Stanley Cavell's assertion that, "our fundamental relation to the world is not one of knowing"⁷ and his subsequent walking back of this claim with the statement that, "the point of forgoing

⁶ A version of this problem can be seen in Weber's theorization of disenchantment. His figure of the savage is one who still "knows" about his tools. The savage rescues knowledge from the critique of intellectualization by granting it solace beyond the forces of rationalization. Savage forms of expertise may have a different kind of relation to skillful practice and everyday life than is the case for "Western societies" but, for Weber's savage, knowing remains the fundament of action.

⁷ Cavell, Stanley. 1996. *A pitch of philosophy: Autobiographical exercises*. Harvard University Press. 79.

knowledge is, of course, to know.”⁸

Although critiques of epistemology in the humanities and social sciences have produced rich toolsets for recognizing different kinds of knowledge, this chapter makes the case that too little work has been done on the specific question of what it means to know something. In the chapter, I differentiate between knowing as a potentially private form of certainty and knowing as an embodied relation that is inherently social. Second, I suggest that knowing in anthropology need not be built either on the knowledge of others (i.e. knowing about how they know) or on the penetration into the implicit epistemologies on which they supposedly ground their lives. Knowing can also be an attribute conferred onto the anthropologist by an interlocutor who seeks to preserve their ability to not-know. Thus a foundation of anthropological knowing can be built not in the knowledge of others but in how their willingness to forgo knowing lends a human quality to their actions and their relation to the world.

In raising the possibility of not-knowing, I do not claim that American acupuncture practice dissociates itself from knowledge and knowing—far from it. I spent hours talking with practitioners, locked in the details of technical questions about the epistemic basis of their assessments, their understanding of the specific techniques that make up their skill sets, what actions to take for different disorders, safety procedures, professional boundaries, and the like. Many of them are information hounds, always trying to expand their clinical knowledge of disorders and treatments. My more limited claim is that knowing does not empower all therapeutic activities and

⁸ Cavell, *Must we mean what we say*, 325.

should therefore not be the sole framework of an ethnographic approach; not-knowing too has its place and various efficacies. For practitioners, the ability to perceive without needing to know expands awareness and enables their acceptance of the patient as more than just a problem to be solved. My ethnography supports this claim in the case of acupuncture but I believe that it can be relevant for any therapeutic practices and indeed for an understanding of expertise more generally.

Not-knowing and practitioner perception

Whereas Lara might have been seen as inexperienced within the profession, Callum could not. When I first interviewed Callum, he had been practicing for over a decade, owned a well-known clinic employing several acupuncturists, was the president of a regional acupuncture association, and was active in local institutional and legislative matters involving acupuncture regulation. Where Lara tended to speak pointedly, energetically, and polemically, Callum's way of speaking was laid back. Yet despite differences in standing, experience, and attitude and despite the fact they were trained in different schools and practiced in different parts of the country, his unwillingness to place knowing at the fundament of skill sounds remarkably like hers.

VK: What, to you, are the meridians?

Callum: What, to me, are the meridians?

VK: Yeah. What are they?

Callum: My sense is that they are areas or zones of the body which have concentrations of energy moving through them. And in some ways, perhaps similar to blood vessels and/or nerve pathways, the energy flows through the body in somewhat more concentrated areas but goes throughout every cell and all throughout the entire body but then kind of accumulates into more condensed areas which we would call meridians but don't have obviously any actual structure at least nothing that we can find in a material fashion. I suppose if we could see energy more clearly than we might find them to be relatively distinct. But you know, no one really knows. I can't say I know for sure what meridians actually are. That's just my impression—sort of like an energetic template if you will that runs through the whole body.

What started as a technical description of the meridians ended in a disavowal. The pattern was one I encountered many times not only in interviews but in everyday conversations around acupuncture clinics.⁹ A patient would ask how acupuncture works or why particular points are chosen and practitioners would qualify their explanations as merely metaphorical or impressionistic. A conceptual model for acupuncture would take shape only to be immediately undermined by some form of

⁹ Not-knowing also permeates the acupuncture literature. For instance, when asked by patients how acupuncture works, Andy Wegman response, "this is really the million-dollar question. The easiest answer we can offer, in bio-medical terms, is that no one has a definitive explanation. There have been many attempts to nail down The One Reason acupuncture works, but to our knowledge no one has got it – yet." Wegman, Andy. 2012. *Why did you put that needle there?*. Manchester Acupuncture Studio. 5.

not-knowing.

Callum's description of energetic zones and pathways coursing through the body sounds like a way of knowing. What then are we to make of Callum's insistence that, "no one really knows" and "I can't say for sure?" Is this an expression of uncertainty or something more? Is there not a contradiction in an acupuncturist who, in the space of a few breaths, both provides and refuses an explanation? I put a version of these questions to Callum the next time it came up:

Callum: I love treating MDs like that because it's always really kind of mind-blowing to them. because there's no real way for them to wrap their logical brain around what just happened to them. But, I don't claim to understand it either when I talk to them. I'm like, "I know. It's weird. This is how I kind of picture it" and I go back to the reflective analogy.

VK: In a way, you can say that you are understanding it, and understanding it very well.

Callum: I understand it probably as well as, I don't know, 80% of people practicing it. I just am giving myself plenty of room for masters that exist that have a much deeper understanding or appreciation on levels that I can't really perceive or comprehend. And then, I'm understanding it probably significantly better than the vast majority of laymen but I still don't pretend to understand it actually with a capital U and really get it. It's just sort of a mysterious thing.

VK: Do you think that you leave some of that information or those conceptual areas open purposely? Do you think you're purposely kind of saying, "well the fact that I don't know or the mystery of it is a good thing to have? It's a good quality to keep?"

Callum: I don't know if I leave it open intentionally to generate mystery even though that isn't really true to some extent. I think it's, to me, more of an actual acknowledgment of the limitations of our perceptions and our intellects and our ability to really understand the body and the universe. To presume that somehow we know why things happen is, to me, a bit of an arrogance that I have a hard time swallowing myself. I think it's just we've come a long way. We've got a lot of good theories. We can see a lot of things that happen but if we really come right down to the whys of most of the things that happen we fall short of any actual definite answers. And, that's true of anybody and everybody.

In this tale, when physicians admit to their confusion in the face of efficacy that they cannot explain, they hand Callum a golden opportunity to identify the distinct bodies of knowledge that legitimized his practice. Based on his training and experience, he is certainly prepared to frame acupuncture as a variant but legitimate form of doctoring. But, he does not. Even when I led him in that direction ("In a way, you can say..."), Callum would not follow. His acupuncture remained a "mysterious thing."

An appreciation of mystery is essential for both Lara and Callum. Lara associates

it with active engagement with a patient because it resists a static end-point. Callum, suspicious of “understanding with a capital U,” argues that the unknown must be tolerated because of an ultimate inability to determine the “whys” that underlie phenomena. These ideas are less a form of mystification than the acceptance of the unknown. What they describe is not quite a matter of medical uncertainty, a concept that has had a long history in the social science of medicine and has been posited as a major motif in biomedical practice.^{10,11,12} Undoubtedly, both mystery and uncertainty share a concern with the boundary between what is and is not known. I would caution against any easy conversion between them, however, as they approach this boundary from opposite sides. Uncertainty lurks on the horizon of the unknown with one foot squarely in the known. Mystery resides in the depths of the unknown, reaching towards the known, perhaps in vain. Mystery here carries its old religious sense as in the *mysterion* of the New Testament: “that which awaits disclosure or interpretation.”¹³ Uncertainty is more the residue of a rationalized approach. It indicates that a process of disclosure or interpretation is underway but incomplete. It is often given that in biomedicine, uncertainty is ideally a transitional phase. As medical students become doctors, their personal uncertainty “to some extent gives way as students acquire greater medical knowledge and competence.”¹⁴ Biomedical research aims to address

¹⁰ Fox, Renee C. 1969. “Training for uncertainty.” In *The student-physician: Introductory studies in the sociology of medical education*, edited by R. K. Merton, G. Reader, and P. L. Kendall, 207–241. Harvard University Press.

¹¹ Fox, Renee. 1980. “The evolution of medical uncertainty.” *The Milbank Memorial Fund Quarterly*. Health and Society, 1–49.

¹² Fox, Renee C. 2000. “Medical uncertainty revisited.” In *Handbook of social studies in health and medicine*, edited by G. L. Albrecht, R. Fitzpatrick, and S. C. Scrimshaw, 409–425. Sage Publications.

¹³ Danker, Frederick William. 2009. *The concise Greek-English lexicon of the New Testament*. University of Chicago Press. 238.

¹⁴ Atkinson. “Training for certainty,” 950.

uncertainties that are not a matter of personal competence but holes in the state of medical knowledge. Callum and Lara associate the desire for resolving knowledge with biomedicine, which they use as a foil for their own preference to “stay open” and “acknowledge the limitations of our perceptions and intellects.” They are fully aware that not-knowing could be regarded as a form of personal incompetence.

Renee Fox, an early scholar of medical uncertainty, gives us a succinct image of its importance within pedagogies of medical perception:

The ability to ‘see what you ought to see’, ‘feel what you ought to feel’, and ‘hear what you ought to hear’, [medical] students assure us, is premised upon a ‘knowledge of what you’re supposed to observe’, an ordered method for making these observations, and a great deal of practice in medical ways of perceiving.”¹⁵

The lesson articulated by these students is less about what they see than about the gap between “what they see” and “what they ought to see.” A version of Fox’s observation would later be identified by Michel Foucault as the medical gaze, an act of perception that he identifies with the emergence of modern medicine. The power of the medical gaze is derived from a system of knowledge that is built upon a technical language.¹⁶ Seeing what ought to be seen is dictated by the necessity of producing a smooth transition from seeing to saying and upon a movement from the contingencies of the

¹⁵ Fox, “Training for uncertainty,” 214.

¹⁶ Foucault, Michel. 1994. *The birth of the clinic: An archaeology of medical perception*. Translated by A. M. Sheridan. Routledge.

clinical moment to the formalities of rationalized medical discourse.

Lara and Callum refuse to comport their perception to better fit rationalized ways of knowing or speaking.¹⁷ Not-knowing opens perceptive awareness towards what is felt without the burden of what ought to be felt. Attention shifts from the validity of sense experience to its utility. Mystery, after all, presents the problem not of an identifiable gap between here and there but of being lost. Lara and Callum express what could be phrased as a skepticism towards knowledge but might better be called its disregard.¹⁸

I should emphasize that the distinction that I am trying to make often appears as a way of differentiating between biomedicine and Chinese medicine but this formulation is neither universal nor necessary. Biomedicine, as portrayed by Lara and Callum, is a rhetorical device that contrasts with the way that they do acupuncture. Other practitioners framed their practices in comparison not to those in biomedicine but to differences within Chinese medical thought itself. Here is what another acupuncturist, Kristen, said of awakening the Daoist side of her practice.

Kristen: [In Daoism,] there's no judgment. Which has helped my understanding of how we talk about Chinese medicine all the time as Daoist but it can really be

¹⁷ Of course, the statement of these students could be read differently. I have particular reservations about the all too easy reduction of this pedagogy of medical perception into a form of discipline.

¹⁸ In articulating his approach to phenomenology, Merleau-Ponty makes a similar case that perception and the projects of objective epistemology are mutually exclusive of one another. He describes the scope of perception as an "indeterminate horizon" whereas objectivity begins with the determinate objects that have already been constituted through the work of attention and retroactively returns certain indeterminacies to perception (33). Merleau-Ponty claims that knowledge starts only when perception stops. The trick of objective empiricism is that it presents itself as the transmission of objects from reality into the realms of concept and discourse. Merleau-Ponty, Maurice. 2012. *The Phenomenology of Perception*. Routledge.

Confucian. We're always correcting things. When I started thinking about it for a while, I was like, I don't even know how to practice medicine if I'm trying to not judge what's going on. That's why it's so nice, [to do something] like Shiatsu. [With Shiatsu, I can say], "I don't really know, but this is what I'm finding physically." Or pulses. I'm not going to use my mind. I'm just going to go with what I feel in the pulse. Because so much of the mind-stuff gets really Confucian about what I need to correct in this person, what I need to fix.

Here the difference between Confucian and Daoist forms of practice marks a move away from knowledge and towards feeling and finding. Kristen indicates the development of the Daoist side of her practice by using the example of first Shiatsu then pulse-taking both of which are best felt from under the shadow of not-knowing.

Although not all acupuncturists take pulses, it is, without doubt, one of the most standard practices I have observed. Practitioners typically take pulses before treatment by placing the index, middle and ring fingers over the radial pulse of the patient's opposite hand. Here the comparisons end, however. Some practitioners take the pulse of both wrists at once, others one at a time, and some feel the carotid pulse as well. Some take pulses for a few seconds, others for five minutes or more. Some return to the pulse repeatedly throughout and after the treatment while others do it only once. Some differentiate between depths and positions of the pulses while others seek a single overall impression. Although the variety of terms and systems that practitioners use to record pulse findings is vast, practitioners seemed to agree that a cultivated feeling for

the pulse is essential and that the feel of the pulse could not be communicated unambiguously or duplicated by a machine. In other words, pulse taking cannot be fully disenchanted into a body of knowledge without mysterious or incalculable forces. The features of pulse reading are specific to the practitioner's field of attention. The pulse, like the face of a loved one, comes to be recognized through familiarity.¹⁹

In pulse-taking, we can see how not-knowing is not just a protest against biomedical hegemony and the medical gaze. It is a setting aside of the need to know in favor of greater awareness. In practice, this means a greater emphasis on techniques of attention. I remember a time when I was shadowing Emma through her clinic as she attended to a few last patients before breaking for lunch. She stopped suddenly, remarking to herself, "that's my husband's cough." I hadn't heard any coughing at all but followed her to the waiting area in the hall outside the clinic's front door. "There you are," she said with relief when she saw her husband waiting for her patiently on a couch in the hall. The moment of recognition did not break from the patterns of clinical attention employed by Emma. If anything it exemplified the simultaneous openness and acuity of her sensorium, far more than any lexicon or criteria of perceptive findings that I could produce.

¹⁹ When I see the face of my mother in my daughter, I am not necessarily exercising an attention to detail or applying a particular set of criteria for recognition. On the contrary, details and criteria may emerge only in hindsight.

Patient transactions of not-knowing

In my fieldwork, I also found not-knowing to be an important way in which patients expressed their experiences, particularly with regard to “unexplained” symptoms. I believe it no coincidence that fatigue, chronic pain, depression, “stress,” and digestive disorders are both the most common of unexplained symptoms²⁰ and those most commonly treated by acupuncturists.^{21,22} Many corners of biomedicine do not tolerate disorders that are difficult to explain. Acupuncture, itself a mysterious practice within a demystified medical system, has no such qualms. Patients with unexplained symptoms can be accepted into acupuncture without fear of being stigmatized as a difficult case.

To put this claim into context, let me describe the experiences of an acupuncture patient named Greg. When I first met him, he had received acupuncture several times a month for just under two years. When we met, he was eager to participate in my research. I observed a number of his treatments, interacted with him around the clinic, and met him for lunch a number of times to talk about his experiences. He told me that he had first come to acupuncture in the midst of a protracted and unexplained illness, one for which no physiological or neurological ground could be found.

Greg’s experience of illness could have been diagnosed in terms of “medically unexplained symptoms” (MUS), though his physicians never classified it that way. He

²⁰ Creed, Francis, Henningsen, Peter, & Fink, Per. 2011. *Medically unexplained symptoms, somatisation and bodily distress: Developing better clinical services*. Cambridge University Press.

²¹ Cassidy, Clare Monad. 1998. “Chinese medicine users in the United States. Part I: Utilization, satisfaction, medical plurality.” *The Journal of Alternative & Complementary Medicine*, 4, 17–27.

²² Rugg, Sue, Charlotte Paterson, Nicky Britten, Jackie Bridges, and Peter Griffiths. 2011. “Traditional acupuncture for people with medically unexplained symptoms: A longitudinal qualitative study of patients’ experiences.” *Br J Gen Pract* 61 (587): 306–315.

had visited a range of doctors and specialists in an attempt to get treatment or even a diagnosis for his disorder. As is typical with MUS, his symptoms had become “medically suspect even when they are experientially devastating.”²³ When I asked Greg how he described his condition to his doctors and specialists, he began with a description of what the illness itself felt like but seamlessly slipped into a language more fitting to the work of differential diagnosis, a process of elimination by way of a list of symptoms and disorders he didn’t have.

Greg: No, I don’t have this symptom. No, ok, it’s not this [pathophysiology].

Nothing wrong with your brain. I mean, that was the key: there’s no neurological issues. They don’t see anything awry. It’s not MS. It’s not all these other things I thought it could have been, I guess. All the things came up blank and my [organ in question] looked perfect. I mean, in terms of the neurology and in terms of the anatomy, I’m normal looking. They had nothing after that so it was like ‘ok, good luck!’ They were kind of just like ‘good luck, we can’t help you.’

Greg never felt acknowledged by his doctors. He felt that as long as his illness could not be secured as a definite object of knowledge it would fall outside of their scope of care. Tired of being shuttled to new medical specialists who never offered him anything, Greg slowly stopped seeking what he called “normal” medical care. When a friend

²³ Barker, Kristin K. 2008. “Electronic support groups, patient-consumers, and medicalization: The case of contested illness.” *Journal of Health and Social Behavior* 49 (1): 20–36. 21.

recommended acupuncture, he was skeptical at first but it seemed different enough to be worth a try. Speaking over lunch one day, Greg shared how his experience with acupuncture was different from the moment he stepped in the clinic:

Greg: Emma [my acupuncturist] did my intake and like, *listened*. And like, genuinely listened and was like, “I’m here and I’m listening to you.” And also was kind of like, “I don’t have an answer necessarily but I’m gonna give you a shot.” [The doctors I had seen before,] they were like “I don’t have an answer but you’re crazy.” Or “I don’t have an answer but don’t worry about it.” Not that those doctors don’t care. I can’t say that they didn’t. I don’t know them. But, the whole situation doesn’t exhibit or create the sense that that’s there.

Greg quickly accepted acupuncture, at least according to his retelling, because it received him as a person rather than a problem that needs to “have an answer.” He had been disoriented within the strange world of his illness with the distinct sense that his doctors “disbelieved” in his experiences and suspected that his exile was self-imposed. Emma put him at ease not by providing new epistemic landmarks but by accepting the unknown and agreeing to accompany him despite its threats and vagaries.

It was his initial health history, not treatment, that Greg used to describe the relief he found in his acupuncturist. This intake, ostensibly performed to collect information, became an expression of an expanded scope of care, its attentiveness embodied in the act of listening. Such listening must be understood as more than just

the acquisition of sensory knowledge or as one pole of a communication process. It is part of the coming together of two persons. The gesture reassured Greg that his acupuncturist would be there and could listen without the need to know.

Greg brought his own versions of not-knowing too. Highly educated and very inquisitive, he told me that:

Greg: I don't really understand acupuncture *at all*. It's kind of funny actually considering as someone who reads or researches and all these other things. It's funny that I haven't spent time on the internet [researching] like, 'what is acupuncture supposedly doing?' I haven't. With acupuncture, I feel I don't need to know, which is funny because I'm the kind of person who usually *needs* to know.

Because his doctors had not given his illness a name, Greg had done a great deal of reading through and interacting with other patients on online forums. Through his research, he even found a description and a name that fit his symptoms. He tried to find out everything he could about what was known about the disorder and other people's experience with it. Yet he never sought sources of knowledge concerning acupuncture despite knowing very little about it.

In general, patients that I interviewed were comfortable knowing almost nothing about how acupuncture works. They often couched this as a kind of pragmatism: acupuncture works and I don't need to know more than that. Here, for instance, is a

passage from an impromptu conversation I had with Cheryl, a semi-retired clerk and long-time acupuncture patient who sought treatment for a variety of chronic pains.

Victor: Do you think of, or wonder about, or ask about how it works, how it is that acupuncture treats these things?

Cheryl: It's kind of a mystery. You know I just kind of know that this is... it's not scientific but it has been effective for millenniums. I mean people have been doing this forever. So, there's something about the energy along the meridians of the, you know, body. So, they'll stick a needle in your toe and your arm will hurt or some-such thing. It's just kind of, it's—so it's just sort of surprising sometimes when I jump when the needle goes in somewhere down in here. The needle went in and I jumped and she said, “oh yeah that's a back point.” And that was the reason I came in is because my back was sore so it made sense that if you hit a back point it might cause a little jolt. So, I don't really know how it works. I have no understanding of that really.

Victor: And that doesn't ummm—You're OK with that?

Cheryl: Umhmm (Affirmative). I'm pretty pragmatic. If something works, that's the most important.

Victor: It's important that it works and not necessarily—You don't feel like you need to understand?

Cheryl: Yeah.

Victor: OK. I know it's kind of hard to ask those types of questions without

sounding judgmental, but I think it's really interesting to me how important it is and how much people, for any type of treatment, how much is enough to know about it. Because, you're never gonna understand it on an expert level, any of the medical treatments.

Cheryl: It's funny because with Western medicine I want to know more.

Victor: Oh, you do want to know more? Okay.

Cheryl: Yeah. It's sort of interesting that I, particularly with drugs and stuff, I want to know because I don't think it's possible to take a drug without it having some effect. You know side effects. You know when you look up the side effects of almost any medication it can cause—like medicine for heart palpitation can cause heart palpitations. It's just kind of nutty that way with Western medicine. And, because this is all based on—it's all based on energy, it doesn't seem to do that. It doesn't seem to have those negative side effects.

There is a stark difference in the way that Cheryl thinks about acupuncture and how she thinks about what she calls Western medicine. She is able to provide a kind of explanation (“something about the energy along the meridians”) but I hesitate to read too much into it. She uses the mystery in a way that goes beyond mere uncertainty over physiological mechanism. After all, pharmaceuticals are often used without knowledge of an underlying mechanism. It is one thing to not know what a pharmaceutical does however, it is another to say that the proper framework for specifying how it might work is itself unknown. Medications even if not fully understood are still assumed to

have so-called “actions and indications.” The working of the needle, on the other hand, is a mysterious matter.

While not-knowing for Lara and Callum were articulated alongside a much more general sense of mystery, versions of not-knowing held by patients like Greg and Cheryl were more specific to their experience of acupuncture. They differentiated between “Western” or “normal” medicine and acupuncture but the line drawn is not only between Eastern and Western philosophies, medical systems, or ways of explaining and expressing the body and its disorders. For Greg, the difference is evident in the care and attention he received in the act of listening. With Cheryl, it is unclear how much importance she places on the concept of “energy” against that of not-knowing. Perhaps, if I had been able to spend more time with her, I would have a better grasp their relative value for her. The excerpt above is from a brief 20-minute conversation we had outside of an acupuncture clinic after we first met and I did not see her again during my fieldwork. I am, however, leery of the desire for further evidence and the forms of evaluation it might entail. I do not need to know what Cheryl means by “energy” to ascribe significance to the idea that, with acupuncture, she does not need to know.

Even patients with whom I spent a great deal of time were rarely satisfied with their own descriptions for the feelings and sensations elicited by acupuncture. “It’s just this weird feeling,” they would tell me (often apologizing for their lack of clarity about something they felt so vividly). Or, they might talk about a heaviness that is not quite a heaviness, a tingling or pressure that is not quite a tingling or pressure. On the rare

occasion that they would bring up terms like energy or qi, the terms were used very loosely, operating more like floating signifiers than specifying terms. For many, experiences of therapy resisted intellectualization. Resonating with Lara's claim that rigid thinking could be seen as a source of illness, patients regularly reported that acupuncture helped them by "putting my mind at ease" or "getting me out of my head" thus enabling them to return to and re-experience their bodies and themselves. Often this return was an unconscious one. Time on the treatment table with the acupuncture needles was described as lost time when the person is "zoned out" or taking an "acu-nap." In a typical hour treatment, patients spend around 45 minutes lying still with needles in their body. It is from this position that acupuncture seems to do its most potent work.

As Kristen pointed out with respect to the Daoist and Confucian aspects of practice, therapeutic paradigms need not be based on acts of correction in which the doctor strives to reorganize the disorder of illness by aligning it with forms given in medicine. The treatment table can be a space in which rigidity (thinking and otherwise) can be released and relaxed. Not-knowing can be a cue, shared by patients and practitioners, that signals attention to *what is* rather than *what ought to be*. Greg, for instance, told me that he no longer goes to acupuncture to treat the unexplained illness that brought him there. Now he is more concerned with anxiety, a feeling that he hesitated to even tell his doctors out of fear that its presence would eclipse his other symptoms: "in medical spaces if you say things like that, if you share things like that, they sometimes write you off saying 'oh now it's psychosomatic.'" He was confident

that Emma could take his experience as something other than an object to be fit into a matrix of knowledge.

Learned professions

While I found expressions of not-knowing to be common in acupuncture practice, they were by no means universal. Here is how one acupuncturist that I spoke with responded to my suggestion about the importance of not-knowing for the practice.

My personal experience is hard to articulate and hard to put into concrete western terms. We don't really have the terms for it. That can make it hard to talk about but that's different from "not-knowing." We all have to know something. Whether or not it's considered the "absolute truth," who cares? You've got to have a working hypothesis at some point. That's what's interesting about it. I love the fact that we don't know from a western perspective why acupuncture works. It makes it fun.

This statement could be collapsed into Lara's by understanding not-knowing as the production of a provisional knowledge that gains ground by iteration. A vast literature is available to recast resistance to knowing as just a different kind of knowledge (tacit, embodied, or sense knowledge, know-how or practical knowledge, situated or socially

constructed knowledge and so forth). But when is it appropriate to insist that something that could be called not-knowing is just another form of knowledge?

Problems of knowledge (the ways in which it is organized, transmitted, and contested) have always been central within ethnographies of Chinese medicine. However, the possibilities of not-knowing have been eclipsed in this literature by an investigation of differences in forms of knowledge or in their deconstruction. The result has been an increased adherence to methodological approaches that emphasize the epistemic multiplicity. In this section, I will suggest that the attention to multiplicities of knowledge has been driven, on the one hand, by the terms of acupuncture's acceptance into the system of medical professions and, on the other, from its suitability as a test case for a brand of epistemology that has been developed along with the field of science studies. I sketch these influences in order to clarify what it is that I call not-knowing. My approach is indebted to but also diverges from critiques of knowledge that are well-established within both the study of acupuncture and social science more generally.

Although acupuncture had long been practiced both in China and in the West, the intensity of its reintroduction to the global stage in the early 1970s was a revelation for the fields of medicine and scholarship. Reflecting on this period in a 1982 annual review article on "non-Western medical systems," Peter Worsely wrote that "what finally exploded the myth of Western omniscience was the astounding revelation, after 1972, that mastoidectomies, open-heart operations, and the like were being routinely

performed in China (at the rate of 100,000 per year) under acupunctural analgesia.”²⁴

Acupuncture opened the frontiers of medical knowledge while calling the centrality of biomedicine into question. How could a technique that is so simple yet so effective remain unused and even uninvestigated by “omniscient” Western experts for so long? Worsley notes that the miraculous efficacy of acupuncture emboldened the anthropology of medicine to go beyond the study of symbols, signs, beliefs, and social dispositions.

First steps in this direction were being taken in the 1970s by scholars like Charles Leslie²⁵ and Arthur Kleinman²⁶ and would contribute to the formation of medical anthropology as a subdiscipline. For Leslie, the study of Chinese and other Asian medicines was the study of “great traditions” that were decidedly not biomedical yet marked by distinctive scholarly, discursive, and pedagogical institutions. The identification and validation of these medical traditions entailed nothing less than the displacement of scientific biomedicine as an epistemic yardstick. Kleinman, Byron Good, and others brought a critique to biomedical hegemony that questioned its logics of care and emphasized the role of the patient within them. These moves displaced the disembodied voice of objectivity and authority that biomedicine had appropriated for itself. In place of a singular reference point called medicine, scholars imagined multiple medicines and organized this plurality around notions of medical systems, medical

²⁴ Worsley, Peter. 1982. “Non-Western medical systems.” *Annual Review of Anthropology* 11 (1): 315–348. 316.

²⁵ Leslie, Charles. M. ed.. 1976. *Asian medical systems: A comparative study*. University of California Press. 1.

²⁶ Kleinman, Arthur. 1980. *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry*. University of California Press.

sectors (e.g. folk, professional, and popular), and explanatory models.

What to Worsley was the “revelation” of acupuncture was also the result of a successful campaign by the PRC to package, control, and present Chinese medical knowledge as a coherent and regionalized form of expertise. Reports from medical experts sent to China as “envoys of cultural exchange” by the United States, Canada, and several European states were enthusiastic about acupuncture’s potential but were also aware that the PRC had purposely framed and manipulated information on the procedure to serve national interests.²⁷ The PRC’s version of Chinese medicine or “Traditional Chinese Medicine” as it would come to be called was not adequate to the standards of the American medical profession.²⁸ Despite both professional and public excitement to bring acupuncture into the American medical system, there was significant confusion about how to identify Chinese medical knowledge and translate it into the American context. To become a profession what was needed was a body of knowledge to educate practitioners, test their legitimacy, and provide rational backing to the practice. Impatient with biomedical research and its failure to ground acupuncture in physiological principles, many hoped that Chinese medicine could be translated and made compatible with other forms of medical knowledge. It was a task seemingly custom made for anthropologists.

Yet ethnographic and historical research almost immediately threw cold water

²⁷ Taylor, Kim. 2004. *Chinese medicine in early communist China, 1945-1963: A medicine of revolution*. Routledge.

²⁸ Bonica, John J. 1974. “Acupuncture anesthesia in the People’s Republic of China: Implications for American medicine.” *JAMA* 229 (10): 1317–1325.

on the idea of Chinese medicine as a discrete and coherent system of knowledge.²⁹

Writing of fieldwork experience gathered in the Guangzhou College of Traditional Chinese Medicine in 1982, Judith Farquhar showed how rigid adherence to abstract and intellectualized forms of medical knowledge led to untenable contradictions in Chinese medical practice:

My questions about logical contradictions and hypothetical situations had been forged in an intellectual environment quite different from that occupied (and generated) by my teachers in GuangZhou... What began for me as a study of 'culture-specific (Chinese) ways of knowing' had to become much more attentive to the clinical priorities in medical work."³⁰

Expecting to investigate culturally-specific concepts, Farquhar instead found new ways of relating knowledge and practice. Critical of the way Leslie had promoted the "medical systems" framework and of Manfred Porkert's assumption that the foundations of Chinese medicine lay in a system of abstract concepts,³¹ Farquhar rejected the notion of Chinese medicine as "an internally coherent body of inert knowledge - a 'system' - the 'theoretical foundations' of which are absolute, idealized, and ahistorical."³² Instead, she described Chinese medical knowledge as "continuously

²⁹ This is the point at which the socialization and localization of knowledge can be distinguished from its pluralization.

³⁰ Farquhar, Judith. 1994. *Knowing practice: The clinical encounter of Chinese medicine*. Westview Press.

³¹ Porkert, Manfred. 1974. *The theoretical foundations of Chinese medicine: Systems of correspondence*. MIT Press.

³² Farquhar, Judith. 1987. "Problems of knowledge in contemporary Chinese medical discourse." *Social Science*

constituted by social practice” and “[adaptable] to the uses of the present,”³³ which is to say that the coherence of Chinese medicine lay in its social contexts rather than a conceptual system. Farquhar’s approach explicitly drew on a reformulation of epistemology that was circulating among feminists, historians, anthropologists, critical theorists, and sociologists whose critiques of scientific knowledge would become a guiding principle of science studies. This critique rejected a singular notion of knowing in favor of multiple “ways of knowing” that are variously contingent, partial, localized, and embodied.

Donna Haraway in her essay on “situated knowledges”³⁴ exemplifies this approach. She writes of a contradiction between her opposition to the masculine reach of scientific claims and the need to find a broader base on which to “build meanings and bodies that have a chance for life.”³⁵

I think my problem, and “our” problem, is how to have simultaneously an account of radical historical contingency for all knowledge claims and knowing subjects... and [simultaneously] a no-nonsense commitment to faithful accounts of a “real” world, one that can be partially shared and that is friendly to earthwide projects of finite freedom, adequate material abundance, modest meaning in suffering, and limited happiness.³⁶

& *Medicine* 24 (12): 1013–1021.

³³ Farquhar, “Problems of knowledge,” 1020.

³⁴ Haraway, Donna. 1988. “Situated knowledges: The science question in feminism and the privilege of partial perspective.” *Feminist Studies* 14 (3): 575–599. 575.

³⁵ Haraway, “Situated knowledges,” 580.

³⁶ *Ibid*, 578

In other words, Haraway begins with the question of how “we” might project shared claims over the reality of the world yet still leave space for the possible legitimacy of other claims. Her answer to this question is to say that we must “situate” knowledges such that “partiality and not universality is the condition of being heard to make rational knowledge claims.”³⁷ Following Farquhar, ethnographers of Chinese medicine increasingly used analytic approaches that resembled Haraway’s.

Elisabeth Hsu’s ethnography of three distinct modes of Chinese medical transmission (secret, personal, and standardized) is just such an examination of epistemic multiplicity. Based on fieldwork conducted in Kunming in the late 1980s, she used her experience with a Qi Gong healer in a private neighborhood context to elucidate secret knowledge, her time as an apprentice with a senior medical doctor (*laozhongyi*) for personal knowledge, and coursework in the Yunnan College of Traditional Chinese Medicine for standard knowledge. Unlike Farquhar, Hsu’s inquiry into the kinds and social conditions of knowledge draws on comparisons, not between Western and Chinese ways of knowing but between different aspects of Chinese medicine itself. Its “styles of knowing” differ “according to one’s perception of and attitudes to knowledge” and according to how “the meaning of the same term may change as the ways change in which one perceives, expresses, uses, credits, orders, and applies knowledge.”³⁸ Through her investigations, Hsu suggests “abandoning the idea

³⁷ Ibid, 589.

³⁸ Hsu, Elisabeth. 1999. *The transmission of Chinese medicine*. Cambridge University Press. 1.

of a monolithic doctrine and practice of Chinese medicine.”³⁹

Following Hsu, Volker Scheid⁴⁰ and Mei Zhan⁴¹ pushed the idea of Chinese medicine’s multiple epistemologies even further. Both authors drew heavily on theories of the social construction of knowledge adopted from science and technology studies (STS). For Scheid, this meant seeing Chinese medicine as intrinsically “plural,” an ever-transforming result of the many ways that practitioners have “synthesized” different fields to respond to a great variety of conditions. Zhan framed the knowledge of Chinese medicine as a “translocal” result of “multiple and effervescent worlds” in the making. These approaches opened up the conditional, contingent, and emergent qualities of practice for study. Yet even when they avoid reducing Chinese medicine to a way of knowing, knowledge remained central to their methodologies of deconstruction. Zhan explicitly framed her argument as an “ethnography of translocal knowledge production”⁴² and dealt largely with differences and contradictions in knowledge that place, “dis-place,” and “world” Chinese medicine. Scheid’s central concept, plurality, almost always appeared out of differences in elements such as clinical techniques, technical terms, treatment protocols, diagnostic and disease categories, and popularly attributed characteristics of Chinese medicine that are posed as forms of knowledge and then deconstructed.

One unintended effect of the increasing influence of the science studies paradigm

³⁹ Hsu, *Transmission of Chinese medicine*, 6.

⁴⁰ Scheid, Volker. 2002. *Chinese medicine in contemporary China: Plurality and synthesis*. Duke University Press.

⁴¹ Zhan, Mei. 2009. *Other-worldly: Making Chinese medicine through transnational frames*. Duke University Press.

⁴² Zhan, *Other-worldly*, 1

on the anthropology of Chinese medicine has been the increasing authority assumed by the anthropologist at each phase. At first, ethnographic authority worked in alliance with practitioners and regulators of complementary and alternative medical practices to construct bodies of agreed-upon knowledge. Contemporary modes of ethnographic deconstruction however often rely less on a “being there” than on a “being across” many theres and then writing each there’s complexity together, a feat that only the ethnographer can accomplish. In Scheid for example, there is the recognition that his project breaks from the concerns of medical practitioners and patients. He notes the divide between his own postmodern position and the fact that “almost without exception contemporary scholar-physicians [in China] refract Chinese medicine through the lens of modernism... imported Enlightenment models of the concurrent progress of knowledge and time dominate their internal histories of medicine.”⁴³ For better or worse, Schield and Zhan step away from the earlier shared epistemological project that sought to professionalize Chinese medicine through the anthropological identification of a domain of knowledge.

Yet, that project remains a visible component of scholars like Hans Baer,^{44,45} Paul Wolpe,⁴⁶ and Linda Barnes⁴⁷ who have continued to see acupuncture as a challenge to

⁴³ Scheid, *Chinese medicine in contemporary China*, 21.

⁴⁴ Baer, Hans A. 2001. *Biomedicine and alternative healing systems in America: Issues of class, race, ethnicity, and gender*. University of Wisconsin Press.

⁴⁵ Baer, Hans A., and W. C. Cockerham. 2009. “Complementary and Alternative medicine: processes of legitimation, professionalization, and cooption.” In *The New Blackwell Companion to Medical Sociology*, 373–390. Wiley-Blackwell.

⁴⁶ Wolpe, Paul Root. 1985. “The maintenance of professional authority: Acupuncture and the American physician.” *Social Problems* 32 (5): 409–424.

⁴⁷ Barnes, Linda L. 2003. “The acupuncture wars: The professionalizing of American acupuncture—a view from Massachusetts.” *Medical Anthropology* 22 (3): 261–301.

biomedical authority. The notion of translation has been deployed by Barnes,^{48,49} Sonya Pritzker,⁵⁰ Mitra Emad⁵¹ and Zhan⁵² herself to emphasize the role of knowledge with respect to the legitimacy of practice and pedagogy. Undoubtedly, these approaches have helped to frame a useful critique of biomedical authority and have revealed some of the essential contexts and controversies that surround acupuncture practice.

This is where I began my own anthropological project as well—in an attempt to understand the diverse ways that bodies, diseases, and healing practices are imagined against the standardized versions found within institutional and regulatory regimes. The response I received from acupuncturists, however, revealed limits to this approach. Their enthusiasm was not for a new way of differentiating or translating between bodies of knowledge but, as I argued earlier, for a way of setting it aside in favor of awareness.

Knowing as a way of standing in the world

I want to return to the distance between Lara's investment in not-knowing and the kinds of provisional knowing put forward by the claim that, "we all have to know

⁴⁸ Barnes, Linda L. 2005. "American acupuncture and efficacy: Meanings and their points of insertion." *Medical Anthropology Quarterly* 19 (3): 239–266.

⁴⁹ Barnes, Linda L. 1998. "The psychologizing of Chinese healing practices in the United States." *Culture, Medicine and Psychiatry* 22 (4): 413–443.

⁵⁰ Pritzker, Sonya. 2014. *Living translation: Language and the search for resonance in US Chinese medicine*. Berghahn Books.

⁵¹ Emad, Mitra. 2004. "Needling as translation: An anthropologist responds to TSCAs needling colloquium." *Clinical Acupuncture and Oriental Medicine*, 4, 164–168.

⁵² Zhan, *Other-worldly*.

something.” On the one hand, the entry of acupuncture into the system of medical professions and the development of regulatory institutions do rely on the formulation of a body of expert knowledge. On the other, we can count the clinical effects of not-knowing for which I have argued: the transactions it enables, its openness to the unknown, and the expansion of forms of care and perception. Without the recognition of knowing in acupuncture, few would be able to gain the skills and legitimacy needed to practice. Yet without not-knowing, the practice might desiccate into a formal exercise that could not meet the needs of its patients. There seems to be a difference in the criteria of what it means to know that leads to these very different positions.

In looking for ways to articulate this tension, I have found Cavell’s long-standing engagement with skepticism to be insightful. Cavell, of course, is working under the conditions of philosophy, conditions that are not synonymous nor even necessarily adequate to those of anthropology or therapy.⁵³ Still, there is a deep resonance between these projects and the space they find between knowing and not-knowing, uncertainty and despair, between moments in which we must know and those in which we need not.

For Cavell, skepticism connects particular instances of uncertainty (is the mushroom I picked is *Volvariella volvacea* or *Amanita phalloides*?) to the conviction that no knowledge can have real weight in the final reckoning. With skepticism, Cavell acknowledges the philosophical instinct to defend the certainty of knowing, registers

⁵³ Although Cavell’s difficulty differentiating philosophy from psychotherapy in his introduction to *A Pitch of Philosophy* suggests the possibility. Cavell, Stanley. 1996. *A pitch of philosophy: Autobiographical exercises*. Harvard University Press.

his disappointment, and entertains the impulse to go beyond knowledge. He returns from the destructive edge of skepticism with what he calls its moral,⁵⁴ “namely, that the human creature's basis in the world as a whole, its relation to the world as such, is not that of knowing, anyway not what we think of as knowing.”⁵⁵ Such claims have led David MacArthur to argue that “getting [Cavell’s skepticism] properly into focus allows us to see the importance of aspects of our lives that are not well-viewed from an epistemological point of view... These overlooked aspects of our lives are what I will call matters of not-knowing.”⁵⁶ My use of “not-knowing” here draws on MacArthur’s way of highlighting that any life that falls under the scope of knowing is lived elsewhere too.

The movement of skepticism from a matter of uncertainty to one of not-knowing depends on an ability to think of knowing as a relation (to the world, to others and ourselves) not just a degree of certainty. Here Cavell’s position is explicitly indebted to the work of J. L. Austin and his founding insight that saying “I know” is less a description of a “subjective mental or cognitive state or attitude” and more the performance of a ritual, a way of binding myself to others, and of staking my reputation.⁵⁷ For Austin, knowing tenders an agreement that, if accepted, advances a collective claim. Knowing, in this sense, is fundamentally relational. It is a certainty

⁵⁴ At times, he also calls it the “truth” and “thesis” of skepticism.

⁵⁵ Cavell, Stanley. 1979. *The claim of reason: Wittgenstein, skepticism, morality, and tragedy*. Oxford University Press. 241.

⁵⁶ MacArthur, David. 2014. “Cavell on skepticism and the importance of not-knowing.” *Conversations* 2: 2–23. 8.

⁵⁷ Wisdom, John, J. L. Austin, and A. J. Ayer. 1946. “Symposium: Other minds.” *Proceedings of the Aristotelian Society, Supplementary Volumes*, 122–197. 171.

characterized by its movement through social circles. As with Wittgenstein's investigation of what it would mean to have a "private language," Austin's approach forces us to reconsider what it would mean to have "private knowledge."

For Cavell, Austin has found that "when I say 'I know' I am not claiming to penetrate more deeply or certainly into reality than when I say 'I believe'; I am, rather, taking a different stance toward what I communicate: I give my word, stake my mind, differently—the greater penetration is perhaps into my trustworthiness."⁵⁸ I read Cavell's use of "stance" here as signaling an affinity between the work of philosophy and the body of the philosopher. Knowing is not a precondition for action but a way of standing in relation to a world of others. It is an embodied state or "somatic mode of attention."⁵⁹ Furthermore, for Austin one does not "know" in the abstract: the position required to know that a kettle is boiling is not identical to that for knowing the weight of thistledown.⁶⁰ To not-know is to not feel obligated to comport one's body to maintain a relation of certainty.

Austin and Cavell's analysis of knowing is significantly different from Haraway's vision of knowing as a collection of projects whose "goal is better accounts of the world"⁶¹ just as an embodied relation is different from a situated account. For acupuncturists, a posture that is ideal to effect therapeutic change may not be a good

⁵⁸ Cavell, Stanley. 1994. *In quest of the ordinary: Lines of skepticism and romanticism*. University of Chicago Press. 161.

⁵⁹ Csordas, Thomas J. 1993. "Somatic modes of attention." *Cultural Anthropology* 8 (2): 135–156.

⁶⁰ The examples used by Austin have a very particularly quotidian British quality to them such as knowing that there's a tea-party next door, knowing that "there's a bittern at the bottom of the garden" (151), knowing "that IG Farben worked for war," or knowing "a person by sight or intimately, a town inside out, a proof backwards, a job in every detail, a poem word for word, a Frenchman when we see one" or even "what love (real hunger) is" (152).

⁶¹ Haraway "Situated knowledges," 590.

one from which to make an account. This difference is also relevant when thinking about the theory of pathological processes employed by acupuncturists. Lara, for instance, suggests that “rigid thinking” is a source not only of bad practice but of illness too. A body always and only in a position to know risks becoming stiff.

Yet, Cavell’s skepticism does not discard certainty in favor of a relational view of knowing. Instead, such skepticism shows how problems of knowledge invite us to explore the very human choice between finding the world agreeable and of repudiating our very existence. The trick is to find a place for the skeptic to stand, “a place, perhaps the central secular place, in which the human wish to deny the condition of human existence is expressed; and so long as the denial is essential to what we think of as the human, skepticism cannot, or must not, be denied.”⁶²

One of the most dispiriting aspects of the illness experience is the way it can wrap uncertainty so tightly around us that we lose a place to stand with respect to it. Contemporary medical practices often respond by trying to drive uncertainty away with knowledge: “if something is not knowable, clinicians have simply not found the correct explanatory evidence.”⁶³ The ultimate aim of this brand of medical intervention is a stabilized, self-affirmed, and self-maintained individual. Yet, the aspiration to build a clinical practice on a solid foundation of knowledge encourages practitioners to turn their backs on the very human qualities of self-doubt and self-denial that are often so pervasive with the illness experience. Patients like Greg cannot help but receive this

⁶² Ibid. 5.

⁶³ Atkins, Chloë GK, Keith Brownell, Jude Kornelsen, Robert Woollard, and Andrea Whiteley. 2013. “Silos of silence, stress, and suffering: Patient and physician experiences of MUPS and diagnostic uncertainty.” *AJOB Neuroscience* 4 (3): 3–8. 4.

turning away as a form of rejection. Because not-knowing enables acceptance of the unknown, uncertain forms of suffering can be made clinically available even when they are not (or not yet) objects of knowledge.

Alongside Cavell and Wittgenstein, Veena Das has, across an extended body of work, repeatedly returned to a skepticism whose “temptations and threats... are taken out from the study of the philosopher and reformulated as questions about what it is to live in the face of the unknowability of the world (for my purposes, especially the social world).”⁶⁴ Skepticism there is not the privilege of the anthropologist but a shared sensibility through which ethnography can disclose the vulnerabilities and fractures of a world. The task to which I have set myself here differs. It is not about how one lives in the face of the unknown but how practitioners and patients find agreement in the unknown. I am driven by the intuition that it is only by acknowledging the unknown or by granting it standing in the reality of our world, that the most real question of the clinical encounter can be addressed: what life possible? Certainly, some of the burden of this question falls on problems of knowledge. However, to lean too heavily on knowing and to fully embrace the dream of demystification with its promise that acts of knowing can sufficiently ground medical encounters is akin to the desire to banish skepticism from the domain of reason.

⁶⁴ Das, Veena. (1998). “Wittgenstein and anthropology.” *Annual Review of Anthropology*, 27, 171–195. 183.

The task of anthropology, medicine, and healing

Farquhar begins her ethnography with a scene of instruction that conveys not a particular instance or revelatory moment but a gradual process of inculcation into Chinese medicine.

I sometimes pointed out apparent contradictions between textbooks or clinical scenarios in which conflicting explanations might be equally plausible. My question often was “How do doctors know which statement or explanation is correct?” Invariably the answer was “We take experience [jingyan] to be our guide,” or, rebuking me for my literal-mindedness, “We take practice [shijian] to be the main thing.” Later, in interviews with a few senior Chinese doctors (formal affairs in which the wisdom I collected was almost indistinguishable from their published writings), these statements came up again and again: Questions about disagreements between doctors, the work of textbook committees, the design of medical college curricula, and the involved technical disputes between schools of thought were all met with the same insistence on experience and practice.⁶⁵

Farquhar’s epistemological inquiry (how do doctors know?) is persistently redirected towards the centrality of experience and practice. Her initial questions assumed that Chinese medicine was a collection of theoretical statements and explanations, an

⁶⁵ Farquhar, *Knowing Practice*. 1.

abstract way of knowing. Her interlocutors, on the other hand, understand such theoretical forms of knowledge in a different way. To take up this new practice of medicine, Farquhar is not encouraged to exchange one body of theories and concepts for another. Her concept of knowledge itself must change. The lesson Farquhar learns from her experience is an appreciation of the debt that knowing owes to practice in all of its social embeddedness.

But what if I took this scene to mean something else? Suppose that the ideas of experience and practice given by these Chinese medical doctors are not a reformulation of knowing at all. Perhaps, the anthropologist is being implored to take something other than knowing to be the main thing. Farquhar comes very close to making this point herself at times, most notably when she says that “in textbooks, classrooms, journal articles, theoretical writing, and clinic rounds, it is not impersonal knowledge but experience—a very historical and social development—that brings order and goodness to the whole evidence of human agency and material powers that is healing.”⁶⁶ Throughout the ethnography, however, this turn to experience is only a prelude for her to return to knowing.

A different lesson is possible, one that might take its cue not from the difference between biomedicine and Chinese medicine but in something like Canguilhem’s distinction between the *doctor* who is “licensed by a diploma sanctioning a conventional set of knowledges” and the *healer* who is “not judged on the basis of what he knows, but

⁶⁶ Ibid, 220.

for his successes.”⁶⁷ In differentiating doctor from healer, Canguilhem reminds us of the enormous work that goes into distinguishing the professional domain of medicine from uninformed, unintentional, or ordinary occasions of therapy. Institutions of doctoring built upon Weberian notions of rational authority must hold that true success is rooted in a body of knowledge while asserting that the success of non-doctors is a trick of the senses or a bit of luck. For Canguilhem, though medicine has suffered under the “abandonment of their healing vocation in favor of regulated undertakings of tracking, treatment, and control,”⁶⁸ doctoring and healing though estranged are not incompatible. He reiterates the point made by Kurt Goldstein: “the doctor who decides to guide the patient along the difficult path of a cure ‘will be able to do so, only if he is completely under the conviction that the physician-patient relationship is not a situation depending alone on the knowledge of the law of causality but that it is a coming to terms of two persons, in which the one wants to help the other gain a pattern that corresponds, as much as possible, to his nature.’”⁶⁹

If knowing is a way of standing in relation to the world and not-knowing has its own efficacies then where do I stand as an anthropologist in relation to the clinical encounter? The search has been a literal one in the sense of learning where and how to stand in a busy clinic, of inhabiting its spaces. It also has the sense of finding a place from which to write.

During fieldwork, I paid close attention when new staff were being trained.

⁶⁷ Canguilhem, Georges. 2006. “Is a pedagogy of healing possible?” Translated by Stephen Miller. *Umbr(a): Incurable*, no. 1: 9–21. 9.

⁶⁸ Canguilhem, “Is a pedagogy of healing possible?,” 17.

⁶⁹ Ibid, 16.

These moments were excellent opportunities to learn the basic administrative operations of clinics without making a pest of myself. One day, I was able to observe Dawn being trained to work at the front desk by Amy, one of the acupuncturists. Amy was showing Dawn how to talk to new patients by giving her hypothetical examples of how a patient might ask about back pain, diabetic conditions, depression, and other illnesses. Dawn was shocked by the range of disorders that acupuncture could treat, “How does acupuncture do that [treat all those things]?” Amy hesitated and shot a quick glance in my direction. “It’s difficult to explain,” she began, “I like to think of it with an electrical analogy.” Acupuncture resets “circuit breakers” in the body that have been tripped by illness and are not resetting on their own. Dawn seemed satisfied by the analogy but Amy wasn’t.

Emma, the owner of the clinic, returned from the treatment room and Amy asked for her opinion on the circuit breaker image. “It’s pretty good,” Emma said adding that “acupuncture basically forces your body to relax so you can heal yourself” like in a state of “supercharged sleep.” Then Emma turned to me saying, “don’t you know this stuff? That’s what your research is about, right?”

I was tempted to respond that I didn’t have an answer but instead found myself saying that in my experience most acupuncturists don’t have an underlying explanation for what they do. They focus on making it work rather than understanding how it works. Emma nodded with a look of almost relief on her face. “We don’t do the work,” she said, “we’re kind of like these nice people that hold this space for them [our patients]. We do a lot of work to make this space safe [but] I don’t make your body do

things.”

I have come to appreciate how Emma was making a space for me too. We both struggled when I first started observing in her clinic. I could only stay there for about 4 hours at a time and we would both end up exhausted. Over time, I came to see the source of our fatigue in our efforts to accommodate each other. We both had significant experience shadowing and being shadowed in an acupuncture clinic: Emma had trained students this way and I had spent years following acupuncturists while training to become one. Yet, my ethnography opened entirely new aspects of the clinic and it took time for us to learn how to manage them. The exercise was one of forging new relations of care and attention.

But ultimately, also of knowing, which was not a way of knowing about an other or an uncovering the epistemological grounds of expertise but a bargain struck in which anthropological knowledge is composed out of respect for the possibility that therapy can occur without knowing. The anthropologist is entrusted (or burdened) with knowledge that is unneeded and often unwanted in relations of therapy. For many patients, release from the burden of needing to know supports the overall therapeutic effect of acupuncture. In deciding whether acupuncture is worth doing or not, the locus of their calculation shifts from the rational judgment of mechanism to an exploration of their feelings of illness and relief. Though they put it to different ends, not-knowing becomes a ground on which practitioners and patients can meet.

Das in her essay on the body and pain offers an image of the anthropologist who

“pawns herself to the words of the other.”⁷⁰ Here I see the anthropologist as more of a pawn-broker. D. W. Winnicott in an essay on the place of the mind in the psyche-soma gives a report of a patient with “suicidal ideas” that “felt completely dissatisfied, as if always aiming to find herself and never succeeding.”⁷¹ Over the course of analysis, the patient began “reliving the birth process” and experienced changes to her breathing, a feeling of pressure on her head, and states of near blackout or unconsciousness. Winnicott determined that “ultimately the patient had to accept annihilation,” first articulated as “death” (hence the suicidal thoughts) but later substituted with “a giving-in,” before finally arriving at “a not-knowing.”

Acceptance of not-knowing produced tremendous relief. ‘Knowing’ became transformed into ‘the analyst knows’, that is to say, ‘behaves reliably in active adaptation to the patient’s needs’. The patient’s whole life had been built up around mental functioning which had become falsely the place (in the head) from which she lived, and her life which had rightly seemed to her false had been developed out of this mental functioning... It happened that on the day on which this work reached its climax the patient stopped writing her diary. This diary had been kept right during the analysis, and it would be possible to reconstruct the whole of her analysis up to this time from it. There is little that the patient could perceive that has not been at least indicated in this diary. The

⁷⁰ Das, Veena. 2007. *Life and words: Violence and the descent into the ordinary*. University of California Press. 39.

⁷¹ Winnicott, Donald. W. 1954. “Mind and its relation to the psyche-soma.” *British Journal of Medical Psychology*, 27 (4), 201–209.

meaning of the diary now became clear - it was a projection of her mental apparatus, and not a picture of the true self, which, in fact, had never lived till, at the bottom of the regression, there came a new chance for the true self to start. The results of this bit of work led to a temporary phase in which there was no mind and no mental functioning. There had to be a temporary phase in which the breathing of her body was all. In this way the patient became able to accept the not-knowing condition because I was holding her and keeping a continuity by my own breathing, while she let go, gave in, knew nothing; it could not be any good however, if I held her and maintained my own continuity of life if she were dead. What made my part operative was that I could see and hear her belly moving as she breathed (like the bird) and therefore I knew that she was alive.⁷²

Winnicott's patient finds relief by placing the burden of knowledge on the therapist. Even more than what MacArthur reads in Cavell, it is this sense of not-knowing that identifies my anthropological position. Of course, I recognize the striking similarity to the experience of receiving acupuncture as recounted earlier: it "puts my mind at ease," "gets me out of my head," and enables a return to an experience of the body and the self.⁷³ Although they rarely begin with the image of death or annihilation, time on the treatment table is often described as lost. There is, furthermore, a notable resonance between the pathological effects that Winnicott attributes to the mental apparatus and

⁷² Winnicott, "Mind and its relation to the psyche-soma," 206.

⁷³ It returns their minds to their "psychesomas" in Winnicott's terms. The "ease" that patients find is both of the psyche and the soma together.

Lara's notion that the need to know contributes to illness.

These kinds of affinities push against the ethnographic desire to situate knowledge in frameworks such as "independent British psychoanalysis," "American translations of Chinese medicine," or "ordinary language philosophy." However, in the image of the diary, Winnicott also gives us competing visions of how knowledge might be handled in ethnography. On the one hand, we have the diary that strives to duplicate. On the other, there is the diary that furnishes material to potentially spur the realization of the true self yet unknown. The former diary records life but does not live because of its absolute separation between the self that is recorded and its mental subject that is a recorder. The latter diary is a place that knows even when the one writing it does not. This act of relinquishing knowledge can also be an act of healing.

Chapter 2

Speculation and discovery:

A genealogy of American acupuncture in the nineteenth century

On May 9, 1822, a small local newspaper in Savannah, Georgia published the following item:

A new remedy has been discovered and introduced into practice in London, for diseases of a rheumatic and nervous nature, which is called Acupuncturation. It consists, as the name imports, in inserting a needle into the muscular parts of the body, to the depth sometimes of an inch, which has in many instances been followed by the best effects.¹

Several aspects of this short text might surprise contemporary readers. For one thing, it occurs approximately 150 years before Americans were supposed to have first encountered acupuncture. Contemporary popular media often portrays acupuncture as arriving in the 1970s but, in fact, the 1820s featured extensive medical discourse about the technique. Acupuncture was so celebrated by French and English medicine that a London medical journal mockingly claimed that, “a little while ago the town rang with

¹ *The Daily Georgian*. 1822. “[Discovered; Practice; London; Nature; Acupuncturation; Instances],” May 9, 1822. 2.

‘acupuncture;’ everybody talked of it; everyone was curing incurable diseases with it.”²

It may also be surprising that the name acupuncturation was expected to “import” the idea of needle insertion even for those unfamiliar with its use as a remedy. Possibly the editors believed that readers knew enough Latin or would be able to interpolate the word’s meaning from the root ‘puncture.’ However, it is also possible, and I would argue probable, that acupuncture was a meaningful term used in non-medical contexts. Acupuncture was an educated variant of puncture, without the many connotations the word is associated with today.

While the early date of this encounter and the possibility of non-medical acupuncture might be surprising, the notion that acupuncture had been “discovered and introduced into practice in London” will likely be downright shocking, if not obviously incorrect. Today, everyone *knows* that acupuncture originated in China and that it is historically and culturally a practice of East Asia. Perhaps editors at *The Georgian* were confused, misread medical reports coming out of Europe, and so mistook a proximal source for acupuncture’s true origin. Perhaps they wrote with an ellipsis to the effect that it should have read: “a new remedy has been discovered [in Asia] and introduced into practice in London.” Yet, if the reader is unfamiliar with acupuncture’s use as a remedy, could they be trusted to know of its origin in Asia?

To what extent did Americans living in 1822 associate acupuncture with East Asia? American medical journals at the time mentioned that the technique had long

² “Hotel Dieu De Caen: Acupuncturation.” 1829. *The Medico-Chirurgical Review, and Journal of Medical Science* XI (XXI). 166.

been used in China and Japan. Recognizing this history is however not the same thing as identifying acupuncture as a cultural practice of East Asia. I can claim, for instance, that paper is a Chinese invention yet not accept it as a technology it is best understood in the context of Chinese theories of the expressive capacity of the written word. I use a version of that argument in this chapter where I take on the assumption that acupuncture was first received in the United States from China and was understood as a component of Chinese medicine. The argument builds on the last chapter where I challenged the idea that acupuncture is best understood as a learned practice based on Chinese medical knowledge.

Acupuncture in the nineteenth century went through periods of boom and bust, circulated through popular and medical discourse, and garnered influential proponents and, to a lesser degree, detractors. Historical investigation can tell us a lot about what Americans of that time thought about acupuncture. In fact, Americans had many different ways of thinking about acupuncture and not all of them were compatible. Some in the medical community classed it as a form of ‘practical medicine’ that was “essentially empirical... [and prejudiced] against all attempts to append theory to the deductions of mere experience.”³ Others took the opposite approach. They used acupuncture to unveil new frontiers of medical theory. Anatomists associated it with specific mechanisms such as fluid dynamics or galvanic conduction. In the latter half of the nineteenth century when China and Japan became sites of trade and travel and in

³ Forbes, John, Alexander Tweedie, and John Conolly, eds. 1832. *The cyclopaedia of practical medicine: Vol 1 ABD - ELE*. Vol. 1. London. 2.

the wake of Chinese immigration, journalists and popular writers used acupuncture to reflect on the character of Asian civilization. Attention to the methods of ‘Chinese doctors’ and an interest in Asian patterns of use had always been a part of thinking about acupuncture but became conspicuous in the 1870s in newspapers, magazines, and in the published accounts of missionaries. Yet at that time, medical journals and textbooks still tended to treat acupuncture as a form of surgery (a classification not commonly made today). These ways of thinking about acupuncture pull its concepts and practices in many different directions.

One aim of this chapter is to tell the history of a time when medical and popular opinion was divided as to whether the Asian history of acupuncture is relevant to its practice. For instance, James Churchill’s treatise, which was the most widely read text on acupuncture and almost certainly the source of the news item in *The Georgian*, states that “[acupuncture] is of Asiatic origin, and China and Japan peculiarly claim it as their own.”⁴ Once noted, however, Churchill treats Asian claims over acupuncture with no special reverence or import. Though its Asian history is acknowledged, Churchill does not view acupuncture strictly through the lens of cultural difference and neither did his reviewers, promoters, nor detractors. This general disinterest in East Asian theories of medicine tends to go unnoticed in most histories of acupuncture in the United States. The rare exception is Dorothy Rosenberg’s dissertation from 1977, which notes that “while [acupuncture’s] origins as an Oriental medical practice were acknowledged, it

⁴ Churchill, James Morss. 1821. *A treatise on acupuncturation*. London: Simpkin & Marshall. 5.

was not presented as a component of a medical system.”⁵

Another aim of this chapter is to take steps toward a Foucaultian history of the present that denaturalizes the way that acupuncture is currently understood. This genealogy attempts to uncover how historical writings on acupuncture might strike readers as strange and in so doing brings focus to conditions of collective estrangement from the past. A history of the present takes the stumbling blocks of historical investigation to tell us about the person running rather than about the road.

Historians and social scientists are often the ones who stumble, particularly when forced to decide what they will and will not call acupuncture. Carol Engelbrecht, for instance, uses the word ‘needling’ to indicate the “rudimentary practice” of acupuncture by Western physicians in the 1800s. She notes that “Ilza Vieth and George Rosen (a medical historian and a sociologist, respectively) independently suggested that there should be a distinction between Asian acupuncture and mere instrumental piercing with a needle.”⁶ I respect this analytic posture and the kind of history that it seeks to tell but am equally discouraged by the need to impose these kinds of assumptions in the reading of acupuncture’s history. Contemporary social scientists should have clear reasons for insisting on analytic distinctions that historical actors do not make.

It is worth thinking about this question in the context of Roberta Bivins’ excellent history of the reception of acupuncture into British medical practice in the eighteenth

⁵ Rosenberg, Dorothy. 1977. “Acupuncture and U.S. medicine: A socio-historical study of the response to the availability of knowledge.” PhD Diss., University of Pittsburgh. 162.

⁶ Engelbracht, Carol. 1993. “The rise and decline of needling (acupuncture): Innovation, reinvention, decision frame and communication.” *Research in the Sociology of Health Care* 10: 141–160. 156.

and nineteenth century.⁷ In many ways, Bivins' text is a prototype for my investigation here. Certainly, I draw on much of the same material as she does. Yet we arrive at seemingly opposite conclusions. She argues that acupuncture can be "read as a palimpsest, inscribed at first with the rich theoretical and cultural structures of Chinese medicine; then over-written with the preoccupations of the physician-observers in East Asia."⁸ Crucially, Bivins claims that a "Chinese substrate" always remains at the base of acupuncture. She asserts that when British physicians ignored Chinese medical theory, "it would be rash to assume that acupuncture's bond with China was obliterated."⁹ What I argue is that it would be equally rash to assume that acupuncture's bond with China was *not* obliterated. In order to determine whether the link between acupuncture and China was preserved or erased, we must turn to the historical evidence at hand, interpret this evidence, and argue our case.

It must be said that Bivins is undoubtedly aware of the contingent aspects of acupuncture's association with China. She differentiates, for instance, between what she calls medical orientalism and medical mercantilism. Under medical orientalism, medical and political figures in Britain sought to collect the beliefs and theoretical concepts of regional medical systems in order "to establish the rank of China among civilized nations—with the additional goal of determining the cause for China's cultural decline."¹⁰ Under the mercantilist approach, "Chinese scholarly knowledge was to be mined for facts and marketable commodities in exactly the same way that China's soil

⁷ Bivins, Roberta. 2000. *Acupuncture, expertise and cross-cultural medicine*. Springer.

⁸ Bivins, *Acupuncture, expertise, and cross-cultural medicine*, 14.

⁹ *Ibid*, 14.

¹⁰ *Ibid*, 5.

might have been mined for minerals and the facts thus collected were to be employed with as little attention to context and meaning as any metal ore.”¹¹ Bivins argues that though aspects of Chinese medicine such as its materia medica and practices like moxibustion could be understood through mercantilism, acupuncture always had an orientalist component. She makes this claim despite showing how a significant number of physicians evaluated acupuncture primarily according to experimental procedures or physiological concepts with as little attention to context and meaning as any metal ore.

What is at stake in my critique of Bivins is whether we see phenomena such as the flexibility of acupuncture theory as a consequence of transmission and translation or whether it emerges from within the course of everyday practice. I agree with Bivins that there is a danger of orientalizing acupuncture so as to “write over” the theoretical and cultural structures of Chinese medicine. Yet, there is also a danger in assuming that prior Chinese structures were coherent enough to be meaningfully overwritten. The forms of acupuncture that the British encountered in China may not have been theoretically and culturally stable. Bivins demonstrates very clearly how, in nineteenth-century Britain, “the term ‘acupuncture’ was stretched to cover many dissimilar uses of the needle, each of which incorporated different and often flatly contradictory instructions on how and when to apply the needle, and each of which demanded a different theoretical basis.”¹² The medical practice “signified by the name ‘acupuncture’ was stable and consistent only in one respect: it always involved the

¹¹ Ibid, 3.

¹² Ibid, 105.

insertion of a needle or needles into the body of the afflicted individual.”¹³ The problem is that Bivins provides no corresponding evidence or analysis of the way that acupuncture was used and thought of in China yet insists on its coherence there. As sensitive and careful as Bivins is regarding differences in Britain, she seems blind to the possibility that similar phenomena might have surrounded the way acupuncture was used within Chinese society at the time.

In fact, significant evidence suggests that acupuncture might have been as marginal and elusive for the Chinese as it would later be for the British. Chinese authors of medical texts from Xu Dachun¹⁴ in 1757 to Li Xuechuan¹⁵ in 1817 regularly described acupuncture as a lost art that had already fallen out of favor as a medical treatment. Kan-Wen Ma, in his brief article on the history of acupuncture in China, claims that “by the second half of the 19th century the general study and practice of acupuncture was at a low ebb.”¹⁶ Writing of the Republican period (1912-1949), Bridie Andrews places acupuncture squarely outside of the literary and scholarly traditions of Chinese medicine and its formal institutions of training. The practice is instead to be found alongside “specialists in minor surgery,... travelling peddlers of Chinese drugs, people who gave medical advice in temples, and massage therapists,” dentists who “would pull a troublesome tooth for a fee and toss it onto the mound that advertised their occupation”¹⁷ and other “travelling healers and itinerant doctors” (river-and-lake

¹³ Ibid, 183.

¹⁴ Xu Dachun, (Yixue yuanliu lun 医学源流论, 1757)

¹⁵ Li Xuechuan, (Zhenjiu fengyuan 针灸逢源, 1817)

¹⁶ Ma, Kan-Wen. 2000. “Acupuncture: Its place in the history of Chinese medicine.” *Acupuncture in Medicine* 18 (2): 88-99. 97.

¹⁷ Andrews, Bridie. 2014. *The making of modern Chinese medicine, 1850-1960*. UBC Press. 26.

doctors, jianghuyi 江湖醫) that operated out of open markets.¹⁸ These sources indicate that acupuncture practice in nineteenth-century China may not have been based on concepts so widely shared and theories so stable as to form an undissolvable substrate at the core of the practice.

If we take away the coherence of Chinese acupuncture then the multiplicities found American acupuncture no longer need be attributed to the phenomenon of cultural transmission. In the sections that follow, I will try to show the ways in which acupuncture emerges out of historical circumstances within the United States and within American medicine.

Part 1: First second impressions (1820-1850)

Defining acupuncture

When acupuncture first arrived in the United States, its proximal source was Europe. Europeans had known about acupuncture since the seventeenth century but French and English doctors did not show much interest in the therapy until the first few decades of the nineteenth. Prior to the publication of Churchill's treatise in 1821, textual evidence of American awareness of acupuncture is limited to medical dictionaries and lexicons. The various descriptions of acupuncture found in these encyclopedic works foreshadow differences that will appear in text throughout the century.

The entry for "acupunctura" in *Quincy's Lexicon Physico-medicum* of 1802 (first

¹⁸ Andrews, *The making of modern Chinese medicine*, 37.

published in London but also printed in New York for American doctors) reads in its entirety: “acupuncture, bleeding performed by making many small punctures.”¹⁹ The text depicts acupuncture as a medical technique used for bleeding with nothing to indicate any connection with Asia. The entry in *Parker & Delaplaine’s New Edinburgh Encyclopaedia* of 1812 describes acupuncture as a treatment for a disease (not a bleeding technique) and makes the association with Asia explicit:

A method of curing diseases by pricking the parts affected with a silver needle. It is much used in Siam, Japan and other oriental nations, where this operation is considered specific for almost every disorder. It is also employed in some parts of America; but more frequently as an ornament than a remedy.²⁰

Here acupuncture is also a technique of pricking but its history and patterns of usage are relevant and connected with East Asia. Interestingly, however, there is also mention of acupuncture in association with ornamental practices of Native Americans implying that acupuncture is not necessarily medical nor Asian. In other sources, the geographic contexts of practice would expand to include France and Britain and the ways that acupuncture was practiced there. In these two definitions of acupuncture, it is characterized primarily as a medical technique. Its association with East Asia is either

¹⁹ Quincy, John. 1802. *Quincy’s lexicon physico-medicum improved, or, a dictionary of the terms employed in medicine, and in such departments of chemistry, natural philosophy, literature, and the arts, as are connected therewith [microform] containing ample explanations of the etymology, signification, and use of those terms.* New York: T. & J. Swords (Firm), bookseller. 13.

²⁰ Brewster, David. 1812. *Parker & Delaplaine’s American edition of the New Edinburgh encyclopaedia.* Philadelphia: Edward Parker, publisher. 129.

secondary or not mentioned at all.

The Dictionary of Arts and Sciences of 1816 has a much more extended entry for acupuncture, which begins: “In the Chinese and Japanese surgery, a method of curing several disorders, by pricking the part affected with a needle.”²¹ The entry depicts acupuncture first and foremost as something that “they” (i.e. the Chinese and Japanese) do. Here acupuncture’s identity as a medical technique is overshadowed by the fact that it belongs to a certain group of people. Across these three definitions, there is no consensus around how Asian and how medical acupuncture was or the extent to which these characteristics were compatible.

Descriptions of acupuncture were tipped in favor of general medical technique with the publication of James Churchill’s *Treatise on Acupuncturation*.²² The book was first published in London in 1821 and quickly attracted attention in the United States where it was widely reviewed, frequently referenced, and commonly cited in American medical discourse. Churchill’s monograph includes a historical and theoretical introduction to acupuncture but is mostly comprised of case reports from the doctor’s practice (Churchill was a member of the Royal College of Surgeons). In part based on interest stimulated by Churchill’s book, a second and almost equally well-received text, Morand’s *Memoir on Acupuncturation*²³ was translated into English and published in 1825. Franklin Bache, a physician practicing in Philadelphia, performed the translation

²¹ Gregory, George. 1816. *A dictionary of arts and sciences in three volumes, first American edition*. Philadelphia: Isaac Peirce.

²² Churchill, *Treatise on acupuncturation*.

²³ Morand, M. 1825. *Memoir on acupuncturation*. Translated by Franklin Bache. Philadelphia: Robert Desilver.

and would soon publish his own acupuncture case studies.²⁴ For the decade or so following Churchill's treatise and with the addition of Morand's monograph, reports on acupuncture from Europe (mostly France and England) became a staple of the medical press. All in all, acupuncture was one of the most hotly discussed medical topics of the 1820s.

In these discussions, acupuncture's Asian history received far less attention than European points of departure. Those that did identify acupuncture as "imported into Europe from the Asiatic and ultra-gangetic nations,"²⁵ moved quickly on to the experiments, findings, and medical speculation of French and English physicians. Here is a typical introductory passage:

Acupuncturation.—This is a surgical operation, and implies puncturing by means of a needle. The operation is of Asiatic origin, and is employed for the removal of local pain. But, notwithstanding the boasted efficacy of the measure among the Asiatics, it has only recently attracted general attention in Europe, where some favourable reports have been made on it in the public journals. It is considered as peculiarly adapted to diseases of a rheumatic character, unattended by inflammation or excitement of the vascular system. According to Berloiz, of Paris, acupuncture dissipates instantly that state of distress which sometimes attends rheumatism of the external muscles

²⁴ Bache, Franklin. 1826. "Cases illustrative of the remedial effects of acupuncturation." *The North American Medical and Surgical Journal* I (2): 311-321.

²⁵ "Mr. Churchill on acupuncture." 1821. *The Medico-Chirurgical Review, and Journal of Medical Science* II (6): 431-36.

subservient to respiration “In the space of one or two minutes, a patient whose sufferings drew from him tears, exclaims he is quite well.”²⁶

Immediately after this passage, we are introduced to a series of European physicians (Dr. Haime, Mr. Churchill, etc.) before receiving information about cases treated and opinions on the operation’s most appropriate uses. Asia is never revisited. The article may have been published in *The New York Medical and Physical Journal*’s “foreign” section, but this heading did not connote exotic remedies. Foreign here meant “European” and implied a center of progress and innovation. Medical historian, Russell Jones has described the 1820s to the 1850s as a “Paris period” in which many prominent American doctors traveled to the great metropolis to train under France’s medical system.²⁷ Because French surgeons like Jules Cloquet and Velpeau were well-known and admired by many within the American medical community, their reputations as scientific experimentalists undoubtedly informed the way that their claims about acupuncture would be understood.

Interestingly, American medical discourse shows evidence that regional differences in Europe, specifically between the France and England, led to different portrayals of acupuncture. English sources for acupuncture tended to be reported through the lens of empiricism while, in the hands of the French, the needle was more often seen as a precise tool of reason through which the anatomist surgeon could

²⁶ “Acupuncturation.” 1822. *The New York Medical and Physical Journal* I (II): 242–245.

²⁷ Jones, Russell M. 1973. “American doctors and the Parisian medical world, 1830-1840.” *Bulletin of the History of Medicine* 47 (2): 177–204.

exercise physiological concepts. For example, in introducing a series of letters from a “distinguished scientific man” in Paris, *The London Magazine* claims that acupuncture should be based on the scientific principles of Parisian physicians. The magazine laments that acupuncture, “as it is practised in England, is indeed merely empirical” and hopes that the work of Cloquet in Paris will “go far to reduce it to a science and give us a glimpse of an important discovery, viz. the proximate cause of pain in disease.”²⁸

Principled or practical

European medicine at the time was on the cusp of a clinical revolution that inspired many in the American medical profession. Particularly in Paris, the clinic had come to serve as a site in which enlightenment ideas of practical training could be coordinated with new scientific advances in anatomical knowledge (in addition to those of chemistry and biology) to produce integrated forms of medical reasoning. New institutional structures implored theory and practice to enjoy a happy marriage with the former providing the epistemic and imaginative framework and the later furnishing empirical verification and concrete know-how. The Parisian clinic could be contrasted, at least in the imagination, with the empiricism of the British doctor’s surgery.

Interestingly, acupuncture entered into Western European medicine of the early 1800s

²⁸ “Experiments at Paris on acupuncturation.” 1825. *London Magazine and Review* 1: 145–148.

straddling this divergence and was used to claim the value of both theoretical and practical approaches.

Anatomists and medical theorists were enthused by what acupuncture could contribute to theoretical questions about electro-magnetism,²⁹ counter-irritation,^{30,31} the regulation of nervous activity,³² and anatomical theories of fluid movement and stagnation within the body. In some cases all of these ideas were used in concert:

Mr. Sarlandiere has lately offered a description of the shape and length of the needles used by the physicians in Japan and China, for acupuncture. He has also given an account of their composition. He claims priority in the use of this remedy in France; and is of the opinion, that the sensations experienced by the patient, on the introduction of the needle, are the result of a galvanic action occasioned by the contact of the metal with the nervous and muscular fibres, and with the fluids which wet the needle.³³

Medical empiricists, on the other hand, expressed the effectiveness of acupuncture through a rapidly expanding case literature. Acupuncture was, for them, a ‘practical

²⁹ “On the galvanic phenomena which accompany the acupuncture.” 1825. *The Medical Review, and Analetic Journal* II (1): 184.

³⁰ Granville, Augustus Bozzi. 1838. *Counter-irritation, its principles and practice: Illustrated by one hundred cases of the most painful and important diseases effectually cured by external applications*. London: John Churchill.

³¹ Pouillet, M. 1825. “On the electro-magnetic phenomena observed in acupuncture.” *Boston Medical Intelligencer* III (25): 98.

³² “Acupuncture: Reflections on the nature of the action of acupuncture.” 1825. *Boston Medical Intelligencer* III (32): 127–28.

³³ “Acupuncture.” 1826. *The North American Medical and Surgical Journal*, no. 1: 225–227. 226.

medicine' that, according to an early newspaper article reporting on the subject, had "no rational hypothesis by which to account for a phenomenon so singular."³⁴ Itinerant doctors, eclectics, and empiricist surgeons were perfectly content using acupuncture without being able to explain it. Churchill is explicit on this point:

I shall here close my subject, not without exciting, perhaps, in the minds of some of my readers, surprise that I have not attempted an hypothesis of the operation. I have by no means made up my mind as to the nature of its action, and rather than venture into speculative reasoning, which may be received as doubtful by some, and visionary by others, I prefer preserving a profound silence.³⁵

Instead, he presented his text in the spirit of "speculation and discovery" and proclaimed that "if... a rational theory, built on sound logical reasoning, be the only evidence to which any value can be attached, then will my efforts have been unavailing and fruitless."³⁶ It was from experience, not theory, that Churchill alleged the good effects of acupunturation and recommended it to others. He saw the remedy as best for "diseases of rheumatic character, and in those injuries of the fibrous structures of the body, which are often observed to arise, (particularly in labouring persons) from violent exertion."³⁷ Inflammatory disease, on the other hand, did not respond well in his

³⁴ *National Advocate*. 1823. "Acupuncturation," September 3, 1823.

³⁵ Churchill, *Treatise on acupuncturation*, 85.

³⁶ *Ibid*, 3.

³⁷ *Ibid*, 24.

experience.

Although Morand dedicated more ink to explaining acupuncture than Churchill, he also favored experience over theory:

Happily, there are wise and enlightened men, true friends of science, who, silencing the voice of the passions, tranquilly meditate the observed facts. Disdaining the pomp of theories, and constantly fearing to stray from the right path, by entering the vast domain of hypothesis, they follow, with perseverance, the straight road of observation, note facts with scrupulous exactitude, and afterwards report them with a candour and good faith, but too rare in our days.³⁸

The image of acupuncture in the early nineteenth century that I am evoking is one of a heterogeneous practice diversified and compartmentalized. Over here it is practical, over there galvanic. For this person, it worked by counter-irritation while for another by affecting nerves. At one time, it is exotic. At another, it is more ready to hand than the common surgical kit. It is practiced both within the theoretical “pomp” supposed to be a part of the Parisian clinic and the more “profound silence” of practical discovery associated with London surgeries.

The 1820s then could be reframed not as a moment of acupuncture’s arrival but one of discursive coalescence when “everybody talked of it and everybody was curing

³⁸ Morand, *Memoire on acupuncture*, 2.

incurable disease with it”³⁹ each in service of their own ideals of medical practice. A critical mass was reached when the discussions of otherwise distinct regions overlapped. While it might have seemed that acupuncture had been rejected or forgotten, it is more accurate to say that it was no longer a matter of debate, though no consensus had been reached. As Michael Devitt shows, “acupuncture became an increasingly popular therapy, taught in many of the nation’s fledgling medical schools, experimented with by some of the nation’s most respected physicians, and employed by doctors and other health care providers throughout the country in both urban and rural settings”⁴⁰

William Rothstein identifies American medicine in the early 1800s as a period of “factiousness,” fracture, and multiplicity.⁴¹ Paul Starr describes it as one of “legitimate complexity” and of “medical sectarianism” forged in the “dialectic between professionalism and the nation’s democratic culture.”⁴² S. M. Shultz associates “this irritable state” with “the rising tide of public distrust aimed at hierarchy and privilege” that was “manifestly prescient of great societal leveling during the Age of the Common Man and of Andrew Jackson’s Presidency.”⁴³ Homeopaths, allopaths, Thompsonians, and a variety of other medical schools of thought trained their doctors separately. Medical licensure did not exist and practices were not centrally regulated. Similar

³⁹ *The Medico-Chirurgical Review*, “Hotel Dieu,” 166.

⁴⁰ Devitt, Michael. 2009. “From remedy highly esteemed to barbarous practice: The rise and fall of acupuncture in nineteenth-century America.” Master’s thesis, University of Missouri-Kansas City. 18.

⁴¹ Rothstein, William. 1972. *American physicians in the 19th century: From sects to science*. Baltimore: Johns Hopkins University Press.

⁴² Starr, Paul. 1982. *The social transformation of American medicine*. New York: Basic Books. 54.

⁴³ Shultz, S. M. 2011. “Quest for professionalism: A biography of the North American Medical and Surgical Journal (182631).” *Journal of Medical Biography* 19 (3): 132–137. 132.

conditions of decentralization existed in Britain where the General Medical Council would not be established until the Medical Act of 1858.

Chinese medicine, even an orientalized version of it, was not a part of the medical multiplicity of this time. The historian Jacques Quen has written that “Western use of acupuncture [in the nineteenth century] was based on a validated misconception of Oriental acupuncture theory”⁴⁴ but by and large American medical journals demonstrated no significant conception or concern for Asian theories of acupuncture. When a translation Ten Rhijne’s *De Acupunctura* of 1689 was published in 1826, the translators purposely avoided sections on Chinese and Japanese medical theory.⁴⁵ This despite the fact that the text itself insists that, “theory furnishes laws, and experience furnishes dexterity: the best practitioner is the one who, taught and trained with both theory and experience, is a master of his art.”⁴⁶ The 1826 translation reduced *De Acupunctura* to a series of aphorisms to convey only “immediate” concerns. The authors professed the hope to separately publish separately a “whole Chinese tract on acupuncture and moxibustion” but whether any such text was published during that period I cannot be sure except to say that if one was it entirely escaped the attention of most American medical journals and popular press alike. Although engagements with

⁴⁴ Quen, Jacques M. 1975. “Acupuncture and western medicine.” *Bulletin of the History of Medicine* 49 (2): 196–205. 200.

⁴⁵ “Wilhelmi Ten Rhyne, M. D. Transisalano. Daventriensis, Dissertatio De Arthritide: Mantissa Schematica: De Acupunctura, Et Orationes Tres I. De Chemi Ac Botanic Antiquitate Et Dignitate. II. De Physiognomia. III. De Monstris. Lond. Impensis R. Chiswell, 1689. 8vo.” 1826. *The North American Medical and Surgical Journal* I (1): 198–204.

⁴⁶ Carrubba, Robert W., and John Z. Bowers. 1974. “The western world’s first detailed treatise on acupuncture: Willem Ten Rhijne’s *De Acupunctura*.” *Journal of the History of Medicine and Allied Sciences* 29 (4): 371–398. 375.

Chinese medical theory can be found in John Elliotson,⁴⁷ Nathaniel Chapman,⁴⁸ and Churchill,⁴⁹ each is a sentence long and extremely perfunctory.

It is possible that promoters of acupuncture at the time avoided discussions of Chinese and Japanese theories because they might cast acupuncture in a negative light. Citing sources like R. A. James,⁵⁰ J. B. DuHalde,⁵¹ Francois Dujardin,⁵² Lorenz Heister,⁵³ and Gerard Van Swieten,⁵⁴ Bivins shows how “in the eighteenth century, acupuncture was invariably described in terms of and in conjunction with its exotic Asian context.”⁵⁵ However, while it is easy to imagine advocates avoiding discussing East Asian theories of acupuncture, why would skeptics ignore the “imperfect and unphilosophical” basis of acupuncture especially given the lack of therapeutic reasoning provided by practitioners like Churchill? Chinese medicine, as a system of either belief or concept,

⁴⁷ “The most obvious purpose of this operation is to allow the escape of the fluid of oedema or anasarca through the skin, or of the blood, when superficially accumulated; but, from an idea that various disorders arose from the confinement of a kind of subtle and acrid vapour, it has been resorted to by the Chinese from time immemorial, for the purpose of allowing this vapour to escape.” Elliotson, John. 1832. “Acupuncture.” In *The Cyclopaedia of Practical Medicine: Vol 1 ABD - ELE*, edited by John Forbes, Alexander Tweedie, and John Conolly, 1:32–34. London. 32.

⁴⁸ “The Japanese suppose that the puncture lets out some hurtful flatus, to the confinement of which in the organs, they attribute all diseases.” Chapman, Nathaniel. 1841. *Essays on practical medicine and surgery V*. Vol. 1. Philadelphia: Lea and Blanchard. 210.

⁴⁹ “The needle must be thrust below the skin, so as to reach the seat of the morbid matter, and giving it a proper vent, consists the main skill of the artist, and the success of the operation is said to depend.” Churchill, *A treatise on acupuncturation*, 17.

⁵⁰ James, R. A. 1743. *Medicinal dictionary; including physic, surgery, anatomy, chymistry, and botany, in all their branches relative to medicine... and an introductory preface, tracing the progress of physic, and explaining the theories which have principally prevail'd in all the ages of the world*. London.

⁵¹ DuHalde, J. B. 1741. *A description of the empire of China and Chinese-Tartary: Together with the kingdoms of Korea, and Tibet: Containing the geography and history (natural as well as civil) of those countries. Enrich'd with general and particular maps, and adorned with a great number of cuts. From the French of P. J. B. DuHalde, Jesuit: With notes geographical, historical, and critical; and other improvements, particularly in the maps, by the translator*. London.

⁵² Dujardin, Francois. 1774. *Histoire de la chirurgie, depuis son origine jusqu'à nos jours*. Paris.

⁵³ Heister, Lorenz. 1743. *A general system of surgery in three parts*. London.

⁵⁴ Van Swieten, Gerard. 1755. *Erläuterungen Zu Den Boerhaaveschen Lehrsätzen*. Vienna.

⁵⁵ Bivins, *Acupuncture, expertise, and cross-cultural medicine*. 95.

was never the grounds for criticism in the medical literature at the time. Critics instead would share suspicions about its general applicability, and would “venture to doubt, not what [Churchill] has said or done himself, but a similarity of success in the hands of others.”⁵⁶ Critical attention to the Asian origins of acupuncture was much less than it had been in the eighteenth century and than it would become again in the twentieth.

Prompt activity and wonderful effects

Even with these very different approaches, most agreed that acupuncture was effective and achieved rapid results. The medical journal article mentioned earlier, for instance, describes how acupuncture “dissipates instantly that state of distress” and that for the particular case mentioned, “in the space of one or two minutes, a patient whose sufferings drew from him tears, exclaims he is quite well.”⁵⁷ Citing Berlioz, Churchill, says that “there are but few remedies possessed of such prompt activity, and which produce such wonderful effects.”⁵⁸ The cases of Berlioz that Churchill relates in his text describe how “the instrument had hardly passed to the depth of a few lines, when the patient said the pain had changed its seat... [A] third puncture made the pain totally disappear, and the patient cried out that I had restored her to life.”⁵⁹ Clear and immediate effect is a prominent theme in the case literature. For example:

⁵⁶ “Acupuncture.” 1824. *The Philadelphia Journal of the Medical and Physical Sciences* 8 (16): 459–460. 460.

⁵⁷ “Acupuncturation.” 1822. *The New York Medical and Physical Journal* I (II): 242–245. 242.

⁵⁸ Churchill, *Treatise on Acupuncturation*, 25.

⁵⁹ *Ibid*, 33.

In two minutes time I observed that he seemed to rest the weight of his body more on his limbs, and in the next instant, without any enquiry being made, he observed, that he felt his limbs stronger from the “pain having left his hips.”⁶⁰

An hour [after needle insertion], the cephalalgia had disappeared, and nothing remained but a slight sensation of weight.⁶¹

Upon the patient’s starting, in consequence of the acute pain produced by this needle, he perceived that his back was no longer painful on motion... the patient now tested the state of his back... and declared that all painful affection was entirely removed.⁶²

Because medical practitioners of the era operated independently without the support of the professional or state infrastructures that exist today, “active therapy was the hallmark of medical practice of the period; the patient was dosed, bled, and blistered by physicians who adhered tenaciously to the belief that the best therapy produced the most rapid and observable symptomatic changes.”⁶³ Acupuncture was also deemed, by Churchill and others, “simple and easy requiring neither practice to give dexterity, nor

⁶⁰ Churchill, *Treatise on acupuncture*, 47.

⁶¹ Morand, *Memoir on Acupuncture*, 40.

⁶² Bache, “Cases illustrative of the remedial effects of acupuncture,” 312.

⁶³ Rothstein, *American physicians in the 19th century*, 41.

adroitness that it may be done with propriety.”⁶⁴ He also found the practice to be relatively safe saying that for a properly qualified surgeon “no danger can arise; as the cautions are but few, and no risk is incurred, if they are attended to.”⁶⁵ Dangers and accidents of the procedure are reported⁶⁶ but such concerns were par for surgical interventions of the period. Devitt also emphasizes the importance of portability. He notes that because “physicians... frequently traveled on horseback or journeyed long distances on foot to treat patients,” needles that “could be stored in a small case and carried in one’s suit or coat pocket”⁶⁷ were often preferred to the relatively bulky surgical kit. As Thomas Neville Bonner shows “apprenticeship remained a central feature of British and American medical training until well past the middle of the [19th] century.”⁶⁸ Itinerant doctors who were trained in either a small proprietary medical school, as an apprentice or both were the order of the day and would have valued the simplicity, safety, ease of use, and obvious effects of acupuncture.

Part 2: Medical institutions and Asian contact (1850-1910)

The 1850s saw two social changes that had a significant impact on the practice of acupuncture in the United States. First, there was the rapid growth of formal

⁶⁴ Churchill, *Treatise on acupuncture*. 13

⁶⁵ Ibid, 13.

⁶⁶ For instance: “Accidents arising from acupuncture.” 1825. *Boston Medical Intelligencer* III (15): 62.

⁶⁷ Devitt, “From remedy highly esteemed,” 104.

⁶⁸ Bonner, Thomas Neville. 1995. *Becoming a physician: Medical education in Britain, France, Germany, and the United States, 1750-1945*. New York: Oxford University Press. 9.

institutions of medicine. American medicine had until this time been the domain of itinerants and entrepreneurs. As the century bore on, medicine began to accrue the political and cultural authority of a learned profession. The American Medical Association (AMA), founded in 1847, quickly became a vanguard in the drive for state standards of licensure, education, and regulation. The practical effects that had once driven interest in acupuncture were not sufficient to ensure its transition into a medicine based on bodies of knowledge that could be recognized and regulated by the state.

A second influential change came with the increasing East Asian influence on Americans' understanding both of themselves and the world around them. New Chinese immigrants arrived on American shores in the 1850s and China and Japan were opened to mercantile and missionary exchange. As Chinatowns sprung up all over the country and the American theory of manifest destiny set its sights on the Pacific, notions of Asian (particularly Chinese) identity and culture took on newfound importance. The sudden appearance and rapid increase in Asian immigration elicited a reactionary response including a series of legal acts—from the US-China Burlingame Treaty of 1868 to the Chinese Exclusion Act of 1882. In this context, acupuncture's association with Asian culture became its primary characteristic. Meanwhile, little emphasis on this connection could be found in the medical literature.

It must also be noted that very little evidence exists to establish that acupuncture was meaningfully practiced among Chinese Americans in the nineteenth century and, even if it did, no evidence suggests that its influence extended to either the greater

medical community or the popular imagination. The correspondence between acupuncture and Chinese culture during this period had more to do with popular notions of racial and national difference than concrete encounters with a medical practice. In other words, the version of Chinese acupuncture that largely appeared in public discourse was more a projection of the Anglo-American imagination than it was a translation or reflection of the actual practices of Chinese doctors.

These two social changes worked against the prior acceptance of acupuncture in the United States. Acupuncture had been popular among medical practitioners in the early nineteenth century but by the early twentieth, it had become equal parts obscure technique and exotic curiosity. The emergent institutions of medicine focused instead on acupuncture's unreliability and inexplicability while in the popular and political sphere, the practice was being used to cast aspersions on the superstitious nature of Asian culture.

Surgical manuals

In medicinal circles, acupuncture continued to be discussed but the fervor that had characterized the 1820s. It could be found in the surgical texts and practice manuals that proliferated in the middle of the nineteenth century. John Biddle, the prominent Philadelphia physician and professor, called acupuncture a "useful remedy in rheumatism, neuralgia, and local paralysis" in all of the many editions of his widely

read *Materia Medica*.⁶⁹ In *New England Popular Medicine*, George Capron stated that “acupuncture has been practiced in this country to some extent, and in a number of cases which have fallen under the author's observation, has been attended with marked success.”⁷⁰ In terms of mechanism of action, he leaves the matter unexplored except to propose notions of fluid absorption when used for certain diseases:

The only cases in which we can rationally expect any benefit to result from it, are chronic rheumatism..., neuralgic or nervous affections, such as sciatica, tic douloureux, nervous headache, local paralysis, and some tumors which contain fluids, as ganglion and hydrocele. By inserting needles into these tumors, a degree of inflammation is excited, the fluid is absorbed, and a cure sometimes follows.⁷¹

Robert Druitt's popular general surgical text, published in America in 1867 under the name, *The Principles and Practice of Modern Surgery* classed acupuncture as a form of minor surgical operation.⁷² Like Capron, the mechanism of action for disorders like hydrocele and ascites is described as “permitting the serum to exude into the cellular tissue.”⁷³ For neuralgia, however, it is said to be “very efficacious... but it is by no

⁶⁹ For instance: Biddle, John B. 1852. *Review of materia medica for the use of students*. Philadelphia: Lindsay and Blakiston. 15.

⁷⁰ Capron, George. 1846. *New England popular medicine*. Providence: J.F. Moore. 12.

⁷¹ Capron, *New England popular medicine*, 12.

⁷² Druitt, Robert. 1867. *The principles and practice of modern surgery*. Philadelphia: Henry C. Lea. 605

⁷³ Druit, *Principles and practice*, 605.

means easy to explain its operation."⁷⁴ Interestingly, this passage expands significantly on the description of acupuncture Druitt provided in his *Surgeon's Vade Mecum*, where he said little more than, "its utility is very problematical."⁷⁵ Druitt's attention to acupuncture expands with later editions of his text thus contradicting the notion that interest diminished as physicians had more experience with the therapy.

Samuel Gross, an American surgeon and prominent figure in the professionalization of medicine, covered acupuncture in his manual on surgery.⁷⁶ Like others, he classed it as a form of counter-irritation and concludes that although it "has been employed in a great variety of affections... its advantages have been much overrated, and the practice, borrowed from the Chinese and Japanese, has fallen into disrepute."⁷⁷ Even so, Gross still recommended acupuncture for hydrocele and radial cure for hernia.

As many historians have noted, the 'father of modern medicine' himself, William Osler, also included acupuncture in his medical textbook.⁷⁸ Osler recommended acupuncture for lumbago and sciatica. He wrote that "acupuncture is, in acute cases, the most efficient treatment [for lumbago]... in many instances the relief is immediate, and I can corroborate fully the statements of Ringer, who taught this practice, as to its extraordinary and prompt efficacy in many instances."⁷⁹ His recommendation

⁷⁴ Ibid, 605.

⁷⁵ Druitt, Robert. 1839. *The Surgeon's Vade Mecum: A Handbook of the Principles and Practices of Surgery*. London: Henry Renshaw and John Churchill. 389.

⁷⁶ Gross, Samuel D. 1872. *A System of Surgery; Pathological, Diagnostic, Therapeutic, and Operative*. 5th ed. Vol. 1. Philadelphia: Henry C. Lea.

⁷⁷ Gross, *A System of Surgery*, 487.

⁷⁸ Osler, William. 1892. *The Principles and Practice of Medicine*. Edinburgh: Young J. Pentland.

⁷⁹ Osler, *Principles and Practice*, 282.

continued to be made as late as 1912 when Albert Sidney Morrow wrote that acupuncture can be used for either “the purpose of relieving the tension in swollen or edematous areas, or [used] directly into muscles or nerves for the relief of the pain of muscular rheumatism or of neuritis... with greatest success in lumbago and sciatica.”⁸⁰

These and other texts hint at how close acupuncture was to being accepted into the emerging order of American medical institutions at the turn of the century. Such potential would go unrealized however and by the 1920s, acupuncture had slipped out of medical practice. The technique had never been overtly confronted, rejected, or discredited, as had been the case with Mesmerism and Perkinism at the beginning of the nineteenth century. I agree with Devitt who suggests that “no single factor is responsible for the poor reputation acupuncture acquired during [the second half of the nineteenth century]”⁸¹ and though a detailed argument of how and why acupuncture fell out of medical practice is beyond the scope of this chapter, I would like to suggest several contributing factors.

American medicine of later periods would assume that acupuncture fell out of favor because it was ineffective (that it had always been more superstition than therapy) or that the foreignness of its concepts would not fit with the newfound dominance of science in medicine. These notions do not hold up to historical scrutiny, however. The foreignness of acupuncture did not seem to be of much concern to medical practitioners or patients of the period. Even the idea that acupuncture was French or British had been

⁸⁰ Morrow, Albert Sidney. 1912. *Diagnostic and therapeutic technical manual of practical procedures employed in diagnosis and treatment*. Philadelphia and London: W. B. Saunders Company. 159.

⁸¹ Dewitt, “From remedy highly respected,” 160.

lost. The accounts of medical textbooks and surgical manuals show, acupuncture was generally classified as a form of practical surgery and theorized as either mechanically affecting fluid circulation or operating more systematically according to the concept of counter-irritation.

Most of the writing on acupuncture during the period acknowledges its conspicuous effectiveness in many cases. Over the years, medical textbooks continued to support its use for selected disorders. One clue to acupuncture's disappearance is how concern shifted from questions of its efficacy to that of its reliability. The prompt and obvious efficacy of acupuncture when it worked may have contributed to the perception of its unreliability. Because acupuncture was thought to achieve results in the space of a clinical encounter, its failure would also be felt immediately. Unlike other therapies whose lack of efficacy might be clouded by the passage of time or the influence of confounding factors, was seen to either work or fail in the moment. In his biography of William Osler, Harvey Cushing writes of a case in which Osler tried unsuccessfully to treat a patient with back pain:

They proceeded to treat him by acupuncture, a popular procedure of the day, which consists in thrusting a long needle into the muscles of the small of the back. At each jab, the old gentleman is said to have ripped out a string of oaths, and in the end got up and hobbled out, no better of his pain, this, to Osler's great distress, for he had expected to give him immediate relief.⁸²

⁸² Cushing, Harvey. 2010. *The life of Sir William Osler*. Severus Verlag. 177.

It is perhaps ironic that some of the very terms of acupuncture's acceptance in the early nineteenth century helped seal its fate in the latter half. Theories of counter-irritation and the notion of practical medicine did not survive the transition into the twentieth century. As Charles Rosenberg argues, these types of therapies flourished in a social and cultural milieu that located the work of medicine in "the everyday requirements of the doctor-patient relationship"⁸³ and valued interventions with clearly "visible and predictable physiological effects: purges purged, emetics induced vomiting, opium soothed pain and moderated diarrhea."⁸⁴ Even drugs of the period were "exhibited" when administered: "insofar as a particular drug caused a perceptible physiological effect, it produced phenomena which all—the physician, the patient, and the patient's family—could witness (again, the double meaning, with its theological overtones, is instructive) and in which all could participate."⁸⁵ Rosenberg identifies these transformations in medical ideology not with a notion of progress but with the shift away from the complex emotionally and spiritually charged interventions of a home-based practice. The patient's faith in medicine became "based not on a shared nexus of belief and participation in the kind of experience we have described, but rather in the physician and his imputed status, and, indirectly, in that of science itself."⁸⁶ This new medicine demanded intellectual rather than experiential investment. Thus, the

⁸³ Rosenberg, Charles. 1992. *Explaining epidemics and other studies in the history of medicine*. Cambridge University Press. 24.

⁸⁴ Rosenberg, *Explaining epidemics*, 15.

⁸⁵ *Ibid*, 18.

⁸⁶ *Ibid*, 31.

intense and obvious experiences of efficacy that were so important earlier were now outweighed by acupuncture's unreliability and inexplicability. Tethered to practical medical practices, acupuncture went down with their ship.

Another reason that may have helped to precipitate the decline of acupuncture is the increased importance of injections. The kinship between acupuncture and the hypodermic needle was close enough during the period to allow for conceptual overlap. For instance, in his surgical manual of 1893, John Shoemaker states that "acupuncture is rarely resorted to at present, except in the modified form of the hollow needle connected with the hypodermic syringe, which has been already mentioned under methods of administering remedies."⁸⁷ In Morrow's manual of surgery, hypodermic injection, vaccination, acupuncture, and bleeding were all grouped together as surgical techniques.⁸⁸ It is worth speculating that injection might have eclipsed acupuncture as the former became a widely accepted practice. Acupuncture could then, in hindsight, be depicted as a primitive form of injection. Notions of evolution and progress with respect to medical instrumentation could then be asserted in order to reject the acupuncture needle or its predecessor, the bleeding lancet, as bygone relics. The "evolution" of these needling technologies mirrored "progress" with respect to medical concepts: the humoral body is bled, the mechanical/anatomical body is acupunctured, and the cellular chemical body is injected into.

⁸⁷ Shoemaker, John Vietch. 1893. *A practical treatise on materia medica and therapeutics: With especial reference to the clinical application of drugs*. Philadelphia: F.A. Davis. 311.

⁸⁸ Morrow, *Diagnostic and therapeutic manual*.

Scholastic and bedside medicine

In an introductory lecture delivered to students at Harvard medical school in 1867 and later published under the title, “scholastic and bedside teaching,”⁸⁹ the physician, poet, and general polymath Oliver Wendell Holmes Sr. expressed skepticism of the educational value of lectures like the one he was delivering. In the middle of the lecture, Holmes narrates a short fictional tale set in a New England village in the mid-seventeenth century and based on the historical figure of Giles Firman. The story follows a young apprentice as he learns at the feet of Master Firman. Through a series of cases, the old master displays his skill at making close observations and medical judgments. At the close of the story, Holmes opines, “when I compare this direct transfer of the practical experience of a wise man into the mind of a student—every fact one that he can use in the battle of life and death—with the far off, unserviceable ‘scientific’ truths that I and some others are in the habit of teaching, I cannot help asking myself whether, if we concede that our forefathers taught too little, there is not a possibility that we may sometimes attempt to teach too much.”⁹⁰

Holmes’ life in medicine reflects many of the historical phenomena mentioned thus far. In the early 1830s, Holmes trained under James Jackson, a physician in the lineage of old New England masters but also a man of science who had studied

⁸⁹ Holmes, Oliver Wendell. 1891. *Medical essays, 1842-1882*. Riverside Edition. The Writings of Oliver Wendell Holmes Vol. IX. Boston, New York: Houghton, Mifflin and Company.

⁹⁰ Holmes, Oliver Wendell. 1867. *Teaching from the chair and at the bedside: An introductory lecture delivered before the medical class of Harvard University, November 6, 1867*. Boston: David Clapp & Son. 15.

medicine in London. Holmes, like Jackson, always seemed stretched between the bedside medicine of the itinerant doctor and the then rising star of scientific research. In 1933, Holmes traveled to Paris where he learned clinical medicine under the methodical Pierre Charles Alexandre Louis. In a letter home, Holmes wrote, “merely to have breathed a concentrated scientific atmosphere like that of Paris must have an affect on anyone who has lived where stupidity is tolerated, where mediocrity is applauded, and where excellence is defied... I have more fully learned at least three principles since I have been in Paris: not to take authority when I can have facts; not to guess when I can know; not to think a man must take physic because he is sick.”⁹¹ By the end of the 1830s, Holmes had returned to the land where mediocrity is applauded to be granted a medical degree from Harvard. He had a small private practice in Boston, taught medicine (first at Dartmouth, then at Harvard), advocated for medical reforms, and wrote several influential papers including one on the contagiousness of puerperal fever⁹² that has since been hailed as an early example of germ theory.

Holmes was also familiar with acupuncture. In a dissertation on neuralgia from 1837, he lists acupuncture alongside blistering, electricity, moxa, and cold and warm applications as an external treatment.⁹³ His comments on acupuncture are about 200 words long and make no mention of Asia. Instead, he shares the opinions of Cloquet, Halliday, and Narducci and the favorable results they achieved. He also notes that “the

⁹¹ Morse, John Torrey. 1896. *Life and letters of Oliver Wendell Holmes*. Vol. 14. Houghton, Mifflin. 108.

⁹² Holmes, *Medical Essays*.

⁹³ Holmes, Oliver Wendell. 1838. *Boylston prize dissertations for the years 1836 and 1837*. Boston: C.C. Little and J. Brown. 220.

remedy has gone nearly out of fashion."⁹⁴

Holmes mentions acupuncture in his 1867 introductory lecture as well. The passage comes shortly after he tells the story of the apprentice and master practitioner. Here Holmes has no qualms associating acupuncture with "the Japanese heathen" and grouping it with a number of other "appropriated" techniques.

Medicine, sometimes impertinently, often ignorantly, often carelessly called "allopathy," appropriates everything from every source that can be of the slightest use to anybody who is ailing in any way, or like to be ailing from any cause. It learned from a monk how to use antimony, from a Jesuit how to cure agues, from a friar how to cut for stone, from a soldier how to treat gout, from a sailor how to keep off scurvy, from a post-master how to sound the Eustachian tube, from a dairy-maid how to prevent small-pox, and from an old market-woman how to catch the itch-insect. It borrowed acupuncture and the moxa from the Japanese heathen, and was taught the use of lobelia by the American savage. It stands ready today to accept anything from any theorist, from any empiric who can make out a good case for his discovery or his remedy. "Science" is one of its benefactors, but only one, out of many.⁹⁵

Medicine for Holmes was to be built on practical knowledge developed out of

⁹⁴ Holmes, *Prize dissertations*, 220.

⁹⁵ Holmes, *Medical essays*. 289.

first-hand experience. Science contributed its own kind of experiences too but its best advantage was its ability to collect and organize findings from elsewhere. Science secures what experience discovers. In one of his many expressive analogies, Holmes laments that the history of practical medicine resembles the mythical Danaides: “‘Experience’ had been, from time immemorial, pouring its flowing treasures into buckets full of holes. At the existing rate of supply and leakage they would never be filled; nothing would ever be settled in medicine. But cases thoroughly recorded and mathematically analyzed would always be available for future use, and when accumulated in sufficient number would lead to results.”⁹⁶

In a different introductory lecture, this time of 1861, published under the title “border lines of knowledge in some provinces of medical science,”⁹⁷ Holmes speaks specifically about the meridian system of East Asian medicine. He presents it not as a conceptual image of the body but as the culmination of empirical findings. In using the meridians, Japanese doctors “are guided in the performance of acupuncture, marking the safe places to thrust in needles, as we buoy out our ship-channels, and doubtless indicating to learned eyes the spots where incautious meddling had led to those little accidents of shipwreck to which patients are unfortunately liable.”⁹⁸ The meridians are depicted as a kind of rudimentary “regional” or “surgical” anatomy, which divides the body arbitrarily and studies each region independently from the others and without concern for physiological systems. Holmes describes the reasoning behind this form of

⁹⁶ Ibid, 432.

⁹⁷ Ibid.

⁹⁸ Ibid, 223.

anatomy through the analogy of buying a farm: “we are not content with the State map or a geological chart including the estate in question” but “demand an exact survey of that particular property, so that we may know what we are dealing with.”⁹⁹

A variation on this picture of the meridians is given in Holmes’ fictional dialog *Poet at the Breakfast Table*. A character called the “old Master” is explaining how science is not worth much if not grounded in common sense when he mentions “those Japanese figures with the points for acupuncture marked upon it.”¹⁰⁰

They must have had accidents from sticking the needles into the wrong places now and then, but I suppose they didn't say a great deal about those. After a time, say a few centuries of experience, they had their doll all spotted over with safe places for sticking in the needles. That is their way of registering practical knowledge.¹⁰¹

The idea that the meridians express accumulated practical knowledge contrasts sharply with Holmes’ criticisms of homeopathy. Holmes described homeopathy as a way of making money off of the desperation of the sick. He said that “it has no pretensions to be considered as belonging among the sciences” except that “it may be looked upon by a scientific man as a curious object of study among the vagaries of the human mind.”¹⁰²

⁹⁹ Ibid, 223.

¹⁰⁰ Holmes, Oliver Wendell. 1873. *The poet at the breakfast-table. His talks with his fellow-boarders and the reader*. Boston: J.R. Osgood and Company. 121.

¹⁰¹ Holmes, *Poet at the breakfast-table*, 121.

¹⁰² Holmes, *Medical essays*, xiii.

Holmes' treatment of homeopathy has all the hallmarks of medical orientalism except that it is directed at a Western practice.

Holmes wrote *Poet at the Breakfast Table* for a popular audience. Both the context of its writing and its mode of argumentation indicate that Holmes is using acupuncture as an example of how medicine is and should be practiced as much as he is informing his readers about Japanese ideas. It is a component of a larger plea to not displace medicine from the bedside in the rush to root its practice in the principles of science.

Non-medical 'acupuncture'

Thus far, this chapter has dealt largely with medical discourse because interest in acupuncture in early nineteenth-century America was driven largely by the medical community. Acupuncture was used relatively infrequently in the popular domain. The term appeared in some literary sources and technical advice columns where it was regarded as a technical term, a "hard word" as the *Baltimore Gazette* puts it.¹⁰³ As early as 1831 in the novel *Mothers and Daughters*, the prolific 'silver fork writer,' Catherine Gore, was using acupuncture in this way:

"Nothing but a Medea would condemn her offspring to promiscuous confectionary in this land of chemical substitutes" said Lord Grandville,

¹⁰³ In the article, "acupuncture" is listed among other "high sounding and exotic words and grandiloquent phrases" such as tonsorial, vidual eve, and celebitoral retreats. *The Baltimore Gazette*. 1834. "Hard Words," November 18, 1834.

gravely. "Muriatic acid and corrosive sublimate form the staple material of our *pralines and gimblettes*." The baronet was stultified; for the gimblets of his own acquaintance were formed of wood and metal, and pretended to no qualities beyond those of acupuncture."¹⁰⁴

The clever fun of this passage, like much of Gore's work, lies in a kind of linguistic slapstick that mocks the pretense of high-class English. The baronet confuses a French pastry (gimblette) with a small hole-boring tool (gimblet). "Acupuncture" is not at the crux of the joke but is merely enhances its flavor. I read the term as what *The Baltimore Gazette* calls a "phraseological exaggeration." In other words, 'acupuncture' is a fashionable word for 'poking holes.'

Four decades later, we see a very similar use of the term by the poet Mortimer Collins. In both an 1868 poem¹⁰⁵ and an 1873 short story,¹⁰⁶ Collins uses 'acupuncture' to mean an intentional puncture. In the story, a letter is said to deliver acupuncture to its recipient like the sting of an animal.¹⁰⁷ In the poem, a man dismisses his lover's concern for a bee in her hair:

No bee was caught in that sweet hair;

And as to acupuncture, there

¹⁰⁴ Gore, Catherine. 1834. *Mothers and daughters*. Philadelphia: E. L Carey. 166.

¹⁰⁵ Collins, Mortimer. 1868. "Under the limes." *The Charleston Daily News*, August 31, 1868.

¹⁰⁶ Collins, Mortimer. 1873. "Mr. Carington." Edited by Henry King. *The Saint Pauls Magazine* 12: 633-54.

¹⁰⁷ "But it is the nature of this kind of inferior animal to sting under all difficulties; and this letter from the fugitive Russian contained its acupuncture." Collins, "Mr Carington," 634.

Was no such thing.
This only do I know, sometimes
Love roamed beneath those blossoming limes
And Love can sting.

Nothing in the work of Collins or Gore suggests that acupuncture should be understood as being particularly Chinese or even medical. Certainly, the term has a formalistic quality but its nature beyond that is unspecified. 'Acupuncture' seems to be related to 'pricking' as today we might relate an 'incision' to a 'cut.' The term connotes an intentional action framed in an educated and sophisticated manner befitting its Latinate roots. Both Gore and Collins are English but because their work was read, commented on, and republished in American newspapers and periodicals, it can be assumed that they made sense to certain Americans as well.

Acupuncture also appeared occasionally in popular discourse on veterinary medicine. A *New York Daily Tribune* article of 1858 on how to avoid buying a defective horse advises a would-be buyer that:

If a horse be not lame of [splents], they are of less importance than is generally considered to be the case. They will generally yield to blistering or acupuncturing. Still, a splenty horse is, caeteris paribus, to be avoided.¹⁰⁸

¹⁰⁸ *New York Daily Tribune*. 1858. "How to buy a horse: Defects to be detected in the legs and feet," January 20, 1858.

The author makes no effort to explain acupuncture in the way they do with other technical terms like “splents.”¹⁰⁹ This lack of elaboration suggests the familiarity of acupuncture to the horse-buying public. Almost 30 years later, another American newspaper, *The Memphis Daily Appeal*, also mentioned acupuncture as a treatment for diseased horses. The article described the meeting and discussion of veterinary experts on a recent and widespread outbreak of an infectious disease among horses in Arkansas and Mississippi.

In regard to local treatment, several gentlemen present expressed a difference in opinion, but most of them agreed that blistering, or the use of a counter-irritant should be practiced in order to prevent the spread of the disease. The mode of supplying these blisters would, of course, be optional. When this cellular tissue was full of fluid, some preferred opening it by incision, others by acupuncture.¹¹⁰

Acupuncture is presented as a mode of draining fluid to be considered alongside the techniques of blistering and incision. The tone of the article suggests that acupuncture for this purpose is both well known and uncontroversial. I have not conducted much in the way of research into veterinary acupuncture of this period but these newspaper

¹⁰⁹ “Splents are small excrescences of the bone, extruding laterally from the cannon bones, or shanks.”

¹¹⁰ *Memphis Daily Appeal*. 1885. “Horse talk,” July 23, 1885.

articles suggest it would be fruitful to do so. Finlay Dun's veterinary textbook, for example, describes acupuncture simply as "affected by needles three to six inches in length, introduced, especially into the fleshy parts, with a rotatory motion."¹¹¹

A newfound Asian America

The use of acupuncture as a veterinary or non-medical term makes the rise in the orientalist literature even more stark. By the late nineteenth century, China and Japan had both been 'opened' to American trade and missionary work: China via the Opium Wars (1839-1860) and Japan as a result of Commodore Perry's expeditions (1852-1854). At the same time, Chinese immigration to the United States increased dramatically in the early 1850s. With these new currents of trade and travel, the American public struggled to come to grips with the sudden and unheralded proximity of East Asia in the popular imagination.

Acupuncture was caught up in these imaginings. Prior to 1860, the technique had rarely appeared in non-medical sources or media reports on medicine, travel writing and more speculative attempts to describe East Asian culture used acupuncture either to foster curiosity and wonder at this new social frontier or to signify the superstitious nature of East Asians. This is not to say that orientalism did not exist in the United States before 1860 only that it did not appear to be generally connected with

¹¹¹ Dun, Finlay. 1889. *Veterinary medicines: Their actions and uses*. 7th ed., Edinburgh. 68.

acupuncture. With this assertion, I may seem to oppose Linda Barnes's well-supported claim that the West has been racializing, religionizing, and medicalizing the Chinese through medical encounters since long before 1848.¹¹² I, however, am not speaking of "the West" or Chinese medicine generally but of acupuncture in the United States specifically. Barnes takes French, British, American, and German orientalism together and so is not interested in the differences and exchanges between them. Barnes also groups a number of different practices together under the umbrella of "Chinese healing" whereas I am interested only in acupuncture and the ways in which it both was and was not connected with East Asia.

Take for instance the following two passages each taken from American newspapers. The first was published in 1861 in Baltimore's *Daily Exchange* and praises Chinese healthcare. The second is from Philadelphia's *Daily Evening Telegraph* and denigrates Chinese medical practices.

As a people the Chinese are generally a healthy race; epidemics are not frequent, and severe diseases are not common. This may be accounted for by their usual moderate diet, but it is thought that the health of their large cities, where filth unbounded is collected together, arises much from the purifying effects of charcoal, the chief fuel of the Chinese. The abstinence of cold drinks and the use of tea, has probably a beneficial effect; and the free exposure of the

¹¹² Barnes, Linda L. 2009. *Needles, herbs, gods, and ghosts: China, healing, and the west to 1848*. Harvard University Press.

neck prevents attacks of catarrh and sore throat, so common among Europeans... Their system of acupuncture and counter irritation is, doubtless, worthy of study. In Europe it is becoming the practice not to bleed in cases of fever. The Chinese have always opposed it; they say "The body is on fire; why take away the liquid required to cool it?"¹¹³

Acupuncture (pricking with a needle) is the favorite, and indeed almost the only, surgical operation practised by the medical practitioners of China and Japan. It is performed by plunging cold or red-hot silver needles into the muscular portions of the body, the only science of the operator consisting in knowing the precise spot where they should be inserted. This curious performance has been an essential part of native practice from the remotest antiquity, and some forty years ago when, at the recommendation of travelers to China, tried by many French and other European doctors. As it did in one or two cases afford relief, various hypotheses were started to account for its curative power. Some imagined that it afforded a conductor for the escape of an undue accumulation of the electric fluid at the seat of disease. But it was soon found to be useless in the majority of cases, the few in which it did good being of a nature that would have succumbed to any counter-irritating treatment, and it soon fell into entire disuse. The means adopted for acquiring a correct knowledge of where the needle may be inserted are a curious example of misplaced Chinese ingenuity... When the

¹¹³ *The Daily Exchange*. 1861. "Chinese medical practice," July 22, 1861.

necessary skill is required the operator becomes ludicrously enamored of his art, and is ready to perforate his fellow-creatures for any conceivable malady.¹¹⁴

These newspaper articles are among the earliest to describe acupuncture in terms of specifically Chinese beliefs and practices. Previous reporting on acupuncture discussed findings of the medical community and often associated it with innovations coming out of France and Britain. *The Daily Exchange* seems to present Chinese and European practices as commensurable with one another and implies that each has its own ways of performing “acupuncture and counter irritation.” It depicts the Chinese as having always been reasonable about medical bleeding, a procedure that American medicine had only recently rejected. *The Daily Evening Telegraph* is almost universally negative where *The Daily Exchange* was positive. It tells a history of acupuncture in which the technique was tried in the West and found wanting. It should also be noted that these popular sources attributed acupuncture to the Chinese whereas medical sources were much more likely to see it as Japanese (if they saw it as East Asian at all).

Of course, some Americans had direct experience with East Asian medicine. Healing practices flourished in many Chinese communities in the United States. Because state and national laws forbade employing Chinese immigrants, entrepreneurial professions like practicing medicine and selling Chinese herbs/groceries were among the few sources of income left. Several Chinese doctors even catered to non-Asian patients particularly in the Western states and frontier

¹¹⁴ *The Daily Evening Telegraph*. 1870. “Chinese doctors,” August 26, 1870.

regions but also in urban centers in the east. William Bowen defines 1871 to 1912 as the “heyday” of Chinese medicine in California in part because of its broad appeal beyond the Chinese community. During this time, white Americans went to Chinese medical practitioners in significant numbers.

This, however, does not mean that Chinese doctors practiced acupuncture. In his review of advertisements published during this heyday, Bowen found that “Chinese doctors practiced pulse diagnosis and herbal therapy exclusively. There is absolutely no mention of acupuncture or any other Chinese medical technique.”¹¹⁵ I too have found little evidence that any of these practitioners used acupuncture to a significant extent. The ethnographer, Stewart Culin, who detailed many aspects of Chinese life in the United States in the 1880s also made no mention of acupuncture.¹¹⁶ He saw Chinese doctors almost exclusively practicing “noi fo” or internal medicine; they had little understanding of “Ngoi fo” or external practice or surgery.¹¹⁷ He noted that home remedies were also employed but does not include acupuncture among them. The historian, Haiming Liu, has drawn on a wealth of evidence about the nature of Chinese herbal practice in the United States to argue that herbalists attracted non-Chinese patients yet did not change the nature of their medicine to accommodate them. Chinese medicine in America “had to remain distinctly Chinese in order to be effective.”¹¹⁸ Liu

¹¹⁵ Bowen, William M. 2002. “The five eras of Chinese medicine in California.” In *The Chinese in America: A history from Gold Mountain to the New Millennium*, edited by Susie Lan Cassel, 174–92. Alta Mira Press. 183.

¹¹⁶ Culin, Stewart. 1887. “The practice of medicine by the Chinese in America.” *The Medical and Surgical Reporter*.

¹¹⁷ Culin, Stewart. 1887. “Chinese drug stores in America.” *American Journal of Pharmacy* 59 (12).

¹¹⁸ Liu, Haiming. 2005. “Chinese herbalists in the United States.” In *Chinese American Transnationalism: The Flow of People, Resources, and Ideas between China and America during the Exclusion Era*, edited by Sucheng Chan, 136–155. Temple University Press. 137.

describes a complex, open, and cosmopolitan practice that was also unmistakably Chinese. Yet he makes no mention of acupuncture use even as a minor or adjunctive technique.

The one exception to an otherwise absence of evidence for acupuncture is an article on the “Chinese quarter” by the missionary Augustus Ward Loomis in which he claims that “acupuncture is common” there.¹¹⁹ Bowen finds it unclear as to whether Loomis is writing of observations made in the United States or in China. It is possible that Loomis is exaggerating or interpolating based on his experiences in China as Bowen has suggested.¹²⁰ Even if Loomis claims to have witnessed acupuncture taking place in the United States, I find little reason to accept his judgment on its prevalence without further support.¹²¹ Furthermore, if we assume that it was as common a practice as Loomis claims, contact with this therapy by non-Asians was very likely minimal. Chinese medical practitioners did not advertise acupuncture, profit much from it, nor advocate for it politically the way that they did for herbal therapy.

Ironically, in China, acupuncture practice had long been on the decline and had even been banned from the Imperial Medical Academy (Taiyiyuan 太醫院) in 1822 near the very peak of its popularity in the West. As noted earlier, Chinese physicians like Xu

¹¹⁹ Loomis, Augustus Ward. 1869. “Medical art in the Chinese quarter.” *Overland Monthly* 2 (6): 496–506. 499.

¹²⁰ Bowen, William. 1993. “The Americanization of Chinese medicine: A discourse-based study of culture-driven medical change.” PhD diss., University of California, Riverside. 43.

¹²¹ In a footnote, Carol Engelbrecht writes “experts such as Ilza Vieth, the Chinese medical scholar asking questions on needling and her opinion on whether Chinese acupuncture existed on the West Coast during that era (I had not found evidence of practice, yet), she speculated no as did the Librarians at the Bancroft Library. Personal interview at Medical History Group, San Francisco, 1986. The immigrant Chinese did practice acupuncture subrosa in the nineteenth century as I was later to document. The early practice was not documented medically, but by the missionaries who had access to the Chinatowns.” Engelbrecht, “Rise and decline,” 156. I have been able to find anywhere where Engelbrecht documents this and have been unable to uncover any missionary account besides Loomis to support her claims.

Dachun and Li Xuechuan wrote about how acupuncture was being largely ignored within China. Scholars like Kan-wen Ma and Bridie Andrews describe acupuncture as marginalized within China. A popular saying in China at this time was “The study of acupuncture and moxibustion is not appropriate to gentlemen” (針刺，火灸，究非奉君之所宜).¹²²

Furthermore, there is evidence that Anglo-American physicians and other travelers brought their own notions of acupuncture to China as much as they took new ones away. Here is a passage from a report for the Chinese Maritime Customs Service by Dr. A. G. Reid in 1872, a medical officer stationed in Hankou (Wuhan).

This was the only instance of a strangulated hernia met with during the past year, and as rupture is not an infrequent complaint I made enquiries among native practitioners, hoping to learn whether or not they ever employed acupuncture to effect reduction. I found that in Hankow this mode of treatment is rarely employed for any disease, except by a few practitioners from Hunan. In cases of scrotal swellings attended with much pain, whether they be due to hernia or to hydrocele, the needles are not passed directly into the tumour, but are inserted a short depth into the wall of the abdomen on the left side midway between the umbilicus and the anterior superior spine of the ilium, or a little in front of the cartilage of the ninth rib, or into certain parts of the leg or foot. It is believed that in these situations there are special gateways which allow a

¹²² Andrews, *The making of modern Chinese medicine*, 197.

superabundance of air to escape, which is supposed to have collected in quantity in the textures of the scrotum, and impeded the circulation. I was assured that the needles shown me which were of silver and about the size of a darning needle, were never passed more than a quarter of an inch in depth, and most frequently only about one-sixth, and that these shallow punctures were the only kind resorted to by those who here followed this mode of treatment. These instruments are far too clumsy to admit of puncturing the bowel with safety in intestinal pneumatosis or in strangulated hernia. Among hospital patients I have met with some examples of harmless punctures in the extremities or over the ribs, but not with the serious kinds seen in other parts of the empire, and which Hunan medical men inform me are resorted to in their native province.¹²³

It is unclear whether Reid saw acupuncture being performed but he seems to have been shown the needles at least and had a chance to speak at length about its practice. He depicts the encounter as one between two different ways of doing acupuncture (“the needles are not passed directly into the tumour [as I might], but are inserted a short depth into the wall of the abdomen”) not a meeting between acupuncture's source and its derivative. Furthermore, Reid came to Hankou not only with acupuncture in hand but also with the assumption that its practice was much more prevalent in China than it was. He did not stumble across acupuncture but, convinced that it was practiced here,

¹²³ Reid, A. G. 1872. “Report on the health of Hankow for the half year ended 31st March 1872.” *Customs Gazette, Medical Reports*, No 8. January-March, 43-57. Shanghai: The Customs Press. 50.

went in search of it. Although Hankou was not an insignificant inland port at the time, he found no native acupuncturists. Apparently, acupuncture was foreign to them, brought by only the Hunanese and the English.

Conclusion

What did nineteenth-century Americans think of acupuncture? The short unsatisfying answer is that Americans used to think about acupuncture in many different ways. In certain literary circles, it was read as a sophisticated term for pricking with a needle. The American medical community of the 1820s depicted it as a medical innovation coming out of Paris and London. For empirically oriented physicians, it was a surgery discovered in East Asia but not primarily characterized as Asian. For critics, it was often described as a medical fashion that could capture the imagination but not produce much in the way of therapeutic results. Many anatomists and medical scientists saw acupuncture as an example of the operation of one of many physiological theories (galvanism, fluid movement, nervous activity, etc.). Although beliefs about acupuncture were often used in the late nineteenth century to collectively imagine the characteristics of the Chinese as a people, little is known about how those within Chinese immigrant communities thought about it and there is very little evidence that they used it at all.

Collecting together these different versions of acupuncture, I have sought to reveal two crucial contexts for the way that it was thought about and used. The first is

the division between a medicine of scientific principles that are grounded in the research clinic and laboratory and a practical medicine of the itinerant or private practitioner. This tension in American medicine of the nineteenth century reflects what Starr has called a “dialectic between professionalism and the nation’s democratic culture”¹²⁴ and what Holmes invokes in the difference between scholastic and bedside medicine. Acupuncture arrived in the 1820s with an obvious efficacy unmarked by either of these two sides of the medical coin. Debate ensued and each side tried to claim it as their own but acupuncture drifted towards the practical. By the end of the century, American medicine had drifted towards science and looked back only with nostalgia.

The second context for thinking about acupuncture is the rapid emergence of China and East Asia within the American popular imagination. Orientalism though not new took a new urgency as American interests globalized, traders and missionaries traveled to the East in significant numbers, and significant numbers of Chinese immigrants began to live in the United States. Orientalist interest in acupuncture focuses on the conceptual basis of the practice rather than the practice itself and is therefore incompatible with the idea of practical medicine.

So, what does this history say about how acupuncture is thought about today? Stacey Langwick, in her short genealogy of traditional medicine in Tanzania, writes that “scholars of African healing have long recognized that the ethnographic and historical category of medicine is unruly at best.”¹²⁵ Acupuncture in the United States is equally

¹²⁴ Starr, *The social transformation of American medicine*, 54.

¹²⁵ Langwick, Stacey Ann. 2011. *Bodies, politics, and African healing: The matter of maladies in Tanzania*. Indiana University Press. 41.

unruly. The problem is that a genealogy of acupuncture often leads into the very core of biomedical practice, a place that many contemporary scholars have hesitated to venture without assurances that acupuncture will always remain a part of Chinese medicine.

While there is merit to not losing sight of acupuncture's East Asian identity, the need to maintain this association also complicates historical analysis, particularly in the way it exaggerates the relative importance of acupuncture within Chinese medicine.

'Acupuncture' and 'Chinese medicine' have become almost synonymous in the United States today. Yet for Chinese practitioners and patients, acupuncture and Chinese medicine are often exclusive with the latter category reserved for herbal practice. The irony is perhaps most evident in the fact that Oliver Wendell Holmes used the image of acupuncture charts to demonstrate empiric principles at the basis of biomedicine while American Chinese herbalists, who almost universally "based their professional authenticity on Chinese culture"¹²⁶ did not mobilize any images of acupuncture when they marketed themselves to non-Asian clients.

Analysis of cultural diffusion in anthropology has relied heavily on concepts like appropriation, acculturation, and assimilation wherein one culture accepts aspects of another. Much less attention is paid however to diffusion that occurs by way of estrangement. In the nineteenth century, 'acupuncture' goes from being a "hard word" for a general concept in the writing of Catherine Gore to a common word for a foreign concept in the orientalist accounts of the American popular press. As I hope the historical evidence demonstrates, these changes are about more than just the way a

¹²⁶ Liu, "Chinese herbalists," 149.

word is used. It also involves complex transformations in the way that therapy was sought out and practiced. A view of acupuncture as something that bubbles out of the social conditions within the United States is consonant with the thinking of the day but is very different from notions that have dominated acupuncture discourse since the 1970s. John Bower's grand proclamation that "acupuncture has invaded the Western World"¹²⁷ would be completely out of place in any part of the nineteenth century.

Finally, in considering where and when acupuncture can be classed within Chinese medicine, biomedicine, or both, I do not want to lose sight of questions of efficacy. Itinerant practitioners working in a period of factiousness had good reason to value acupuncture's prompt and wondrous effects. In places where medical authority was vested in scientific knowledge rather than the social relations of the clinical encounter, the inexplicability and unreliability of acupuncture mechanisms were a significant problem. Considerations of efficacy meant that accepting acupuncture was not always a matter of accepting foreign ideas but of fitting types of effects to the social circumstances of medical care. As these first two chapters have argued, the history of acupuncture and its present-day uses cannot be understood as the translation and implementation of particular therapeutic concepts but must include horizons of bodily experience and the social relations that develop between doctors, patients, and medical institutions as well. In the chapters that follow, I will examine these experiential, relational, and material aspects of acupuncture practice more directly.

¹²⁷ Bowers, John Z. 1973. "Acupuncture." *Proceedings of the American Philosophical Society* 117 (3): 143–151. 143.

Chapter 3

Of flowers and windowsills:

The poetics of space and material in two American acupuncture clinics

To prevent disease and re-establish vitality, both the acupuncturist and the patient must use the whole universe wisely.¹

I didn't make much of the sunflowers at first except that they were beautiful. The soft tone of their petals gave respite from the late afternoon glare as it bounced off of the windows of an apartment building across the street. On overcast days, the flowers had the opposite effect, standing sharply against the grayness that otherwise permeated the space. On a windowsill in the treatment room, an array of orchids stayed in bloom for years, far longer than any others I have ever seen. In the front room, succulents, ferns, and begonias were evergreen. When I suggested that it was the light that kept the plants so healthy, Emma disagreed. The owner of the clinic and one of its two acupuncturists, she credited the healing qualities of the space itself. Friends and patients often brought sick plants to the clinic to revive them. At least half of the plants on the sill were there temporarily, waiting to be well enough to return home.

The sunflowers may have been temporary but their presence was integral. Their

¹ Lee, Miriam. 1992. *Insights of a senior acupuncturist: One combination of points can treat many diseases*. Blue Poppy Press. 36.

heads bowed to patients as they entered the clinic, returned from the treatment room, or waited on a nearby couch for their appointments. The flowers waited patiently beside the front-desk staff as they managed appointments and collected payments. From the desk on the other side of the bookshelves, acupuncturists could only catch a glimpse of the flowers while they wrote up charts or took medical histories from new patients. And, lest we forget, the sunflowers increasingly caught the eye of an anthropologist trying to figure out why all these things happen the way that they do.

A week later, the sunflowers were gone, replaced by a new bouquet of gold dahlias and chrysanthemums set against a yellow clustering flower that I never could identify. The week after that, orange and gold made way for the fuchsia of peonies, their shade varying from the light pink of a just-opened bud to the much bolder almost neon color of a flower in full bloom. Each week as the arrangements were renewed, a sense of anticipation and satisfaction settled into a rhythm that I found reassuring.

On the desk next to the flowers, I could always find a jar of ginger candy, a box of tissues, a container of earplugs, and a bottle of hand sanitizer. Most new patients refrained from taking candy but, after a few visits, the sweets became a part of treatment for many. One running joke among clinic staff was that patients would riot if they ran out of candy. I never witnessed any riots but on occasions when the jar was near empty, a patient was always the first to notice—usually within a matter of minutes. These and other mundane objects in the clinic went through cycles of consumption and renewal though usually without the fanfare of the flowers or the urgency of the candy. Blankets went to the laundry, staples and crackers were

restocked, printers and scanners were run and reloaded, and a handheld carpet sweeper was used to clean the floor at the end of each shift. Patients put their shoes and coats in a basket and slid them under their treatment chairs only to collect them again at the end of their treatments.

Objects more commonly thought of as essential to acupuncture therapy go through their motions as well: needles are used once and placed in biohazard containers. These containers are disposed of and replaced every month or two. Herbal remedies are prescribed and reordered as appropriate. Patient charts were filled out, filed, and digitized then later pulled and read. Such tasks fit together into an interlocking routine that was very orderly and predictable. None of these activities involves direct patient contact but, depending on the clinic, they can take up anywhere from one-third to half of an acupuncturist's time. History taking, diagnostics, and needling may be iconic elements of acupuncture but they are a small part of what makes a clinic tick.

In the dissertation thus far, I have argued that the typical social scientific approach to acupuncture provides an incomplete and even misleading picture when trying to understand its acceptance and continued use in the United States. My ethnography in the first chapter shows the limits of understanding acupuncture expertise as a particular "way of knowing." In the second chapter, I tell a history that reveals how the East Asian identity of acupuncture need not be assumed in order to understand the way that acupuncture was received and accepted in the nineteenth century. Those chapters also argued for the importance of concepts like awareness,

mystery, and practical medicine in framing the practice. This chapter continues to develop new frameworks, this time by experimenting with the poetics of space and material as it operates in two American acupuncture clinics. I use the flower arrangements of Green Leaf Community Acupuncture as my point of entry but go on to describe a range of other objects that get caught up in therapy. I also examine how patients and practitioners think about and inhabit the clinical space.

Aesthetics and holism

Set against the rhythm of useful tasks, what part do the flowers have to play? The anthropologists Kevin Taylor Anderson² and Marion Katz³ have each argued that objects like flowers establish an aesthetic sensibility that frames the way that acupuncture is experienced and interpreted.⁴ Aesthetic objects mark a contrast between the patient-centered and holistic aspects of Chinese medicine and “the generic institutional quality of many biomedical offices.”⁵ Shocked with how consistently acupuncture patients interpret the insertion of a stainless steel needle into the body as

² Anderson, in his study of acupuncture clinics in Galway, Ireland, became interested in such “atmospheric and aesthetic elements” as a way of explaining how patients come to think of the insertion of a stainless steel needle into the body as natural, non-invasive, and comfortable. Anderson, Kevin Taylor. 2010. “Holistic medicine not ‘torture’: Performing acupuncture in Galway, Ireland.” *Medical Anthropology* 29 (3): 253–277.

³ Katz, whose fieldsites include practices in Southern California, describes the visual vocabulary of acupuncture clinics as deploying “symbolic links to China and Chinese culture” while the use of wood and green plants gives a “sense of individuality and intimacy.” Katz, Marion. 2011. “Chinese medicine in the US: Culture, interaction, and the construction of patient-centered care.” PhD Diss., University of California, Los Angeles. 74.

⁴ Katz, “Chinese medicine in the US,” 74.

⁵ Ibid. 74.

“natural” and “non-invasive,” Anderson turns his analysis to aesthetics. He argues that patients are lead to these interpretations of needling by a variety of visual, acoustic, and discursive cues. He claims that practitioners use “New Age music, wind chimes, burning incense and mugwort, decorative posters, photographs, paintings of Asian landscapes, prints of Chinese calligraphy,[...] anatomical charts mapping the qi meridians,[...] Asian decorations and material accents, along with flower displays, candles, and incense”⁶ to narrow the interpretive field that surrounds needling.

While I agree that Anderson provides a perfectly valid route through the aesthetics of acupuncture clinics, I believe it to be only one route among many. Charts of the meridians usually do make visual reference to their own “asianicity” (as Anderson calls it) with the inclusion of Chinese or Japanese characters or in the style in which the bodies are positioned or depicted. But, other visual vocabularies, including the anatomical conventions of biomedicine, are often more prominent. Many of these charts would not look out of place in the office of other medical specialties. While some people associate ginger candies with the “exotic flavors” of Asia, for others they are just a treat. Peonies and chrysanthemums can find symbolic or material use within Chinese herbalism but they are also familiar flowers bought and sold every day in the United States without connotations of Asia. During fieldwork, I found that the foreignness of acupuncture was especially elusive for patients, who could easily identify the practice as East Asian (mostly Chinese) but rarely portrayed this fact as essential to their experience or understanding of it. The forms of communication that I observed between

⁶ Anderson, “Holistic medicine not ‘torture,’” 260.

practitioners and patients did not depend on a shared Chinese medical lexicon or conceptual framework.

In a large scale survey of patient experiences of Chinese medicine in the United States (n=460), Claire Cassidy concluded that the infrequent use of Chinese medical terms “in a pragmatic sense implies that [survey] respondents were really not buying ‘Chinese medicine,’ but rather, ‘holistic healthcare.’”⁷ Cassidy argues that the preference for American idioms of holistic care over the technical terms of Chinese medicine is evidence that “American users of Chinese medicine are not selecting something ‘exotic’ or ‘foreign,’ but staying close to home and simply seeking practitioners who offer a culturally familiar if not mainstream theory and consequent healthcare delivery design.”⁸ Sylvia Schroer, in her collection and analysis of illness narratives in a British acupuncture clinic, reports similar findings:

Patients rarely used Chinese medical language... preferring instead to talk of changes in mood or energy... Many patients’ narratives revealed a shift during the process of treatment away from what anthropologist Charles Leslie has identified as mechanical theories or physical explanations of illness, towards theories of equilibrium living a balanced life, mind and body working in harmony or ethical theories, seeing treatment as a cleansing process, the pollution, stagnation or ‘bad stuff being removed.’⁹

⁷ Cassidy, Claire M. 1998. “Chinese medicine users in the United States part II: Preferred aspects of care.” *The Journal of Alternative and Complementary Medicine* 4 (2): 189–202. 200.

⁸ Cassidy, “Chinese medicine users part II,” 200.

⁹ Schroer, Sylvia. 2005. “Patients’ explanatory models of acupuncture.” *European Journal of Oriental Medicine*

Even Hugh MacPherson, Lucy Thorpe, and Kate Thomas' study, which asserts that practitioners used "explanatory models taken from Chinese medicine to aid the development of a shared understanding of the patient's condition,"¹⁰ reveals something different on closer examination. In interviews, practitioners talked about how they convey Chinese medical concepts in the language of "simple energetics and alignments and direction and energy and 'stuckness' and so forth," or "in a language like 'stagnation' or 'blockage.'"¹¹ This choice to avoid the technical language of Chinese medicine calls into question the extent to which there are shared concepts or if, as Cassidy claims, the transformation from technical to informal language is significant enough to dislocate Chinese medicine in favor of the compatible but not identical idea of holistic medicine. Cassidy even argues that what Chinese medical practitioners themselves are doing might be more holistic and less Chinese medical than they recognize. Cassidy insists that any model of acupuncture must look at patients' own description of their experiences and not just rely on practitioner ideas about translation.

The problem, however, is that patient depictions of acupuncture are almost always extraordinarily vague. For example, one of Cassidy's survey respondents writes that they "especially appreciate being looked at as a whole being, mind and spirit as well as body, and one body as opposed to separate parts"¹² but gives no concrete sense

5 (1): 34–43. 44.

¹⁰ MacPherson, Hugh, Lucy Thorpe, and Kate Thomas. 2006. "Beyond needling—therapeutic processes in acupuncture care: A qualitative study nested within a low-back pain trial." *Journal of Alternative & Complementary Medicine* 12 (9): 873–880. 878.

¹¹ MacPherson et al, "Beyond needling," 875.

¹² Ibid, 199.

of what that might mean. Patients rarely give any criteria with which to tell when a medical practitioner is looking at her patients as whole beings as opposed to a collection of parts. Similarly, vague descriptions are common in the social scientific literature on acupuncture. At the risk of covering old ground, it is worth presenting a typical example of this sentiment from my fieldwork.

When I first met Tamara, she had already been going to acupuncture regularly for over a year and had no plans of stopping. She could provide specifics about the nature of her head and neck pain and why it led her to seek treatment but she had a much harder time talking about why she continued to do acupuncture and planned to continue indefinitely. The head and neck pain were still there and she still got treatment for them but she also went for a variety of other things.

Tamara: So it hasn't eliminated the pain.

It helps it but, in addition

I mean, I get a different experience every time.

Sometimes I can feel what I know is therapeutic. You know whatever qi or whatever they're talking about. I can feel a difference.

I can feel something running through, coursing through me whatever.

That's kind of unusual.

Sometimes there's nothing else. It's just like taking a little nap when I'm there. And I don't also know how much of it is just because Emma is a really, you know, a really wonderful woman who makes connections with her patients and you just feel better

that someone is looking at you.

(sigh)

I'll put it this way, in a medical culture where if you come in for your elbow, if you say there's pain in your elbow, they'll be looking at your elbow and if you also have like a gaping wound on, you know (laughs and gestures around herself).

She looks at you at the whole person.

Phrases like, "I can feel what I know is therapeutic," underscored with the assertion, "I can feel a difference," can be contrasted with Tamara's inability to verbally articulate the location of even a hypothetical "gaping wound." Soft-spoken but very comfortable speaking, it was unusual for her to struggle to find the right word to express an idea. Thus, I find it quite significant that Tamara conveyed the idea of searching for this wound not verbally but with a gesture of her hands.¹³ For the moment, she surrenders spoken language, a language which then returns with the idea that Emma looks are her as a whole person.

Such inability to specify is not strictly a result of a patient's ignorance about either acupuncture or Chinese medicine. Anderson, for instance, shares a conversation that he had with an acupuncturist about the mechanisms of its therapy:

As one acupuncturist said to me "If patients come in with all this stress and leave

¹³ In my experience, Tamara was not a particularly animated person. Our conversations often took on the mannerisms of two people speaking in a library and trying their best not to disturb others. That is perhaps why this moment stood out for me both in my memory and in my fieldnotes.

feeling totally different I know it's not just the needles." When I asked her to elaborate, she provided me with a rather vague summation, saying, "It's a holistic thing," suggesting that she believes elements other than the needling have a positive effect on the patients.¹⁴

How is an anthropologist to deal with this inability to locate therapeutic mechanisms? In this chapter, I turn not to the discourse of practitioners and patients but instead towards clinical objects and spaces. In my approach, I both follow and resist the ethnographic impulse to fill such gaps in meaning by looking to the context of the clinical setting. On the one hand, there is an unspoken invitation to deploy anthropology's "science of context" to articulate what acupuncturists and patients themselves cannot. But on the other, ethnography must find the proper grounds on which to take this step. The problem is not just of social scientific theory but of ethnographic judgment, of finding approaches that lend themselves to the spirit in which acupuncture is recognized and accepted. If ethnographic description is "thick" but not attuned to the tones and rhythms of therapeutic activity, then an ethnography risks eclipsing the very thing it sought to uncover. Acupuncture therapy, like all life, is awash in meaningless detail. If details are collected and theorized without accounting for the spirit of practice, the resulting descriptions will likely be unfaithful even if accurate. Thus before elaborating beyond what the acupuncturist cannot or will not, it behooves me to ask why it is that so many practitioners seem unable to definitively

¹⁴ Anderson, "Holistic medicine not 'torture,'" 275.

locate clinical actions except to say that they involve a diverse range of actors and objects. What is this spirit that finds value in the indefinite, the vague, or the ambiguous?

In the ethnography that follows, I will explore the clinical spaces of two acupuncture clinics: *Green Leaf Community Acupuncture*, which was owned and operated by Emma Kohn and *Clinton Street Acupuncture* in which Kristen Fischer was one of the central practitioners. My approach focuses on the aesthetic sensibilities and fields of social relations that organize clinical practice. My ethnography begins with a consideration of what might alternatively be called objects, things, or materials. I argue that the heterogeneity of these objects is remarkable not because of their specific meanings but because of their availability for diverse processes of meaning-making. I then discuss how clinical spaces themselves are conceptualized in practice as being held open rather than intentionally arranged so as to control the range of meaning made available to patients. Ultimately, I turn to Martin Heidegger and Gaston Bachelard's ideas about poetic activity to better grasp the creative process in which these objects and spaces participate. This move can be read as a form of theorization but, for me, the turn to a philosophy of poetry works best if taken as another aspect of ethnographic description.

Heidegger and Bachelard are both concerned with the difference between poetics and science as ways of working with material. I am as well. Yet, I am also wary of carelessly folding this difference into the commonly held distinction between natural medicine and biomedicine. There is a temptation to align poetics in acupuncture with

Chinese philosophy, vitalistic theories of the body, and holism while associating the technological interventions of biomedicine with science, Western philosophies, and reductionism. While this dichotomy is often taken up in clinical practice, the dividing line is not as definite as many portrayals of acupuncture make it out to be.

One clear indication that these two dichotomies are not interchangeable is how easily biomedical clinicians have been able to grasp the poetics of therapy especially when many experienced anthropologists struggled with the idea. I remember relaxing one summer afternoon with a pediatrician friend of a friend. I was in the midst of writing proposals for research funding and, in response to the confusion of reviewers, had developed a deep reservoir of frustration with my ability to articulate my project in a way that would make social scientific sense. The physician asked me about my research and I had hardly begun to describe my project before he was able to relate it to his own clinical experiences and provide several adroit examples of the poetics of his clinical encounters. Even though the politics of biomedicine emphasizes technological power, he was well-versed in its poetic sensibility.

Conflicted trajectories

Let me return then to the flower arrangements in Green Leaf. For little over a month, I saw the flowers as a design choice that reinforces the image of acupuncture as natural and comfortable while still professional. But then, trying to trace out local economies of

exchange, I asked Emma where she bought them. She explained that the flowers were from Sam, a patient who couldn't afford to pay for treatment outright. He was responsible for the flowers at his church and would arrange each week's excess to bring to the clinic. Emma explained that "I sort of just treated [Sam] for free and he wanted to bring the flowers. Mostly he was just really excited about making flower arrangements and he had extras. It was a way he felt he was paying that he had thought of and I was super into it because it was gorgeous and beautiful and made everything nice." When Sam would come up in our conversations, Emma could never fully decide whether the flowers were a trade, a gift, or something else. Regardless of what we might call it, the idea for the transaction originated with Sam's friend and roommate, Michael. Michael was a "regular" who came in for treatment almost every day. He knew Emma and Sam well enough to propose the arrangement.

My knowledge of Sam was mostly second hand. I had seen him around the clinic but we were never formally introduced nor did I spend time with him as part of my research. Yet, when I returned to the clinic after a year's absence, I saw no flowers on the desk and immediately thought of him. Emma told me that both Michael and Sam's treatment had more or less run its course. It didn't surprise me but still felt a little strange. I know very little about Sam's case but had taken Michael's presence in the clinic for granted. When Michael had first come in for treatment, he was barely able to walk; Emma assisted him into and out of the treatment chair. Month by month, I watched him grow more mobile. The last few times I saw him, he could get up from treatment and slip out the door without my noticing. Now aware of Sam and Michael's

history with the flowers, I could still see them as “gorgeous and beautiful” but they now also fit into a pattern of social relations rather than an aesthetic design. They were caught up in Emma’s relations of care, the friendship between Sam and Michael, the temporal trajectories of their therapeutic process, and my own vantage point within the clinic.

From early in my fieldwork, my methods included attention to clinical objects. I kept an inventory of them, marked their arrivals, absences, and transformations and observed how and when they were used. After seeing how the flower arrangements indexed a complex social and therapeutic relationship, I realized the need to ask about the origins and histories of objects as well. Unfortunately, this new line of inquiry was time-consuming and could be pursued only selectively so as not to exhaust my interlocutors. The object-histories I collected were quite diverse. Some clinical objects were acquired as formal business purchases, others were gifted, traded, loaned, part of a rental or space-sharing agreement, or required by insurance companies. They came from family, friends, patients, teachers, landlords, and colleagues. This variety was especially evident for private or smaller clinics but even larger integrated practices contained many different types of objects.

I can think, for example, of my own private practice. My treatment table was a graduation gift from my parents, the therapeutic heat lamp from my grandparents. I bought needles through my business but other equipment was given to me by colleagues, teachers, and friends. The shelves on which most of these things sat had originally been bought as a bookcase for my home but ended up in my office when it

didn't fit into a new apartment. I also had four photographs depicting the Lan Su Chinese Garden in Portland, Oregon and its tea house. For a year, I had been lucky enough to have worked in that teahouse and the garden, which is one of the most beautiful places in Portland. The photos were taken by a relative who had them framed when I opened my first private acupuncture practice. They were not the kinds of images that I would have chosen for my practice but I did not reject them either.

Emma refused to use Chinese terms like qi or yin and yang and generally opposed the exoticization of acupuncture as a form of cultural appropriation. Yet, there on the wall of Green Leaf was a chart clearly titled, "Acupoints of Traditional Chinese Medicine." In fact, her clinic had a number of objects that seemed completely incongruous with her therapeutic sensibilities. One day, I noticed a fairly rare and esoteric book on Chinese medicine on the shelf that served as a small library of clinical texts just above her desk.¹⁵ I knew of the book and immediately realized that Emma would despise its abstract approach. I asked her about it and she could not have held the book in lower esteem. "This is nonsense," was one of her least derogatory descriptions of it. "This book is useless for someone trying to help people," was another. With a tone bordering on disappointment, she said that a patient had bought it for her and probably paid almost \$100 for it online. At first, I was intrigued by the number of things in Emma's office that she didn't particularly like but had kept because they were given to her by a friend or patient. Eventually, I stopped counting. They were

¹⁵ Maciocia, Giovanni. 2009. *The psyche in Chinese medicine: Treatment of emotional and mental disharmonies with acupuncture and Chinese herbs*. Churchill Livingstone.

everywhere.

One thing that Emma found especially distasteful was her acupuncture school diploma. “I hate that thing,” she told me on more than one occasion. The diploma hung on the wall next to her desk directly in front of where I spent a lot of my time. The frame never seemed to hang level even though Emma was usually obsessive about keeping the clinic in order. I was particularly amused by the signature it bore from the school’s founder, a well-known acupuncturist who had died five years before the diploma was granted. Apparently, felicitous signatures can be produced even after death. Emma too was entertained by the farce of the signature but even her amusement was charged with the contentious relationship she had with her acupuncture school, a place that she felt stifled her by insisting that she learn what she considered to be the more impractical doctrines of East Asian medicine. Still, the part of the diploma that seemed to bother her the most was her full name, Emmalynn Marjorie Kohn, featured prominently in a bold script in the center of the document. Several times she shared her discomfort with the pretensions of this name. When I suggested to Emma that she could always take the diploma down, she told me that her husband had had it framed for her. I suspect that it was the care behind his gesture that made it possible for Emma to tolerate it, that she hung it not because it means anything for her but because it meant something to him.

For a time, Emma also hung a set of watercolor paintings depicting the Maine coast made by a patient. Emma’s original idea had been to set up a kind of gallery space within the clinic but as her relationship with the patient soured, she couldn’t wait to get

rid of the artwork. Emma confided in me that she had to steel herself when she saw an appointment with that patient on the schedule. The difficulty, as Emma explained it, was the way this person regularly pushed on the critical boundary between being empathic and being an emotional dumping ground. Drawing and maintaining that boundary could demand as much from patients and practitioners as any other aspect of treatment.

The conflicts that bound together such clinical objects carried with them uncertainties and vulnerabilities that threatened the therapeutic project. Some patients get acupuncture treatment once or twice and never return. It was often difficult to connect with these patients but of those with whom I was able to speak many pointed out small things about the atmosphere, the attitude of the practitioner or staff, or even the kinds of words used to talk about acupuncture as reasons for not returning. Small cracks of disagreement could open and lead acupuncturists and patients to a falling out. If symptoms emerged or got worse soon after acupuncture, the needles were implicated. I witnessed several phone calls made from patients concerned that a new symptom or experience was a result of treatment. On many occasions, treatment continued but often the call signaled its end. The inability to identify specific mechanisms of action and the strangeness of the experience was also a problem for some. For others, the cost of regular treatments or the inability to find time for regular appointments was a barrier.

The clinical encounters of Green Leaf always proffer failure. But their conflicts

were also agonistic and lent themselves to therapeutic efficacy.¹⁶ The multipartite quality of these objects allows their involvement in very different processes, obligations, and modes of organization. These possibilities enable them to participate in different projects simultaneously without reduction to a single form. To an extent, they resemble “boundary objects,” a concept which Star and Griesemer developed while investigating the kinds of cooperation without consensus that occurs between the heterogeneous actors, disciplines, and institutions of science.¹⁷ There are key differences, however. Boundary objects use a combination of interpretive flexibility and structural coherence to encompass “a range of very different visions stemming from the intersection of participating social worlds.”¹⁸ Star and Griesemer apply the concept to activities such as the indexing of artifacts in a museum, the construction of ideal types like atlases or species, and the standardization of practices and field sites. These objects are formulated so that fields of study can overlap without confronting each other. In this way, they maintain the distance between these preexisting domains of vision.

The clinical objects that I describe are rarely domain preserving. The prints, paintings, and photographs hung on the walls of the clinic can set a mood, contribute to an exotic aesthetic, materialize a gift economy, and fulfill a social obligation but they blur rather than sharpen the lines between these activities. In Emma’s diploma, for

¹⁶ The notion of agonistics that I am using is drawn from Chantal Mouffe, who argues that the quest for a regime built on fundamental agreement diminishes the ability to engage in politics: “too much emphasis on consensus, together with aversion towards confrontations, leads to apathy and to a disaffection with political participation.” Mouffe, Chantal. 2013. *Agonistics: Thinking the world politically*. Verso Books. 27.

¹⁷ Star, Susan Leigh, and James R. Griesemer. 1989. “Institutional ecology, ‘translations’ and boundary objects: Amateurs and professionals in Berkeley’s Museum of Vertebrate Zoology, 1907-39.” *Social Studies of Science* 19 (3): 387–420.

¹⁸ Star and Griesemer, “Institutional ecology,” 396.

instance, the certifying signature, the appearance of her name, and even the frame hold valances and pull in different directions towards diverse relations without standardizing or specifying how these possibilities are produced. If the boundary object is like a specimen indexed and stored in a museum repository, then the clinical object as I describe it is more like a playground ball. The former is easily taken up in predetermined ways. The later can be associated with many different games but does very little to prevent one game from blending into another, to keep us from making up the rules as we go along, or to limit our ability to generate new rules in the course of play.

One could read Emma's diploma as the result of a standardized process but this does not seem at all the way that she read it. Formal resemblance with the boundary object concept notwithstanding, the spirit of the diploma's use is extraordinarily different. Ethnographic fidelity to this spirit does not fit with methods of thick description that enumerate the possible frameworks for taking these objects nor an explanation that resolves conflicting interpretations. Instead, it supports an openness to creative approaches and the unexpected patterns that stabilize around them. Though unexpected, these patterns are tied to routines that are orderly, regular, predictable, and stable. While I have come to accept that I have limited purchase on what those flowers meant, I could count on their appearance week after week and their association with the ongoing relations between Sam, Emma, and Michael.

Negotiated traditions

On the other side of the country from Emma and Green Leaf was Clinton Street Acupuncture, a space with a much more prominent Asian aesthetic. Just inside the door of Clinton Street, stood a light gray stone statue, about two or three feet high, depicting a woman crowned and robed in the style of a mythical Hindu figure. Photographs of Southeast Asian temples hung next to quilted dragons and scrolls of ink brushed fish. Several small Chinese Buddhist-style statues and figurines could be found on small corner shelves and on the floor of the waiting area. A brightly colored chart of the meridians hung in front of one of the treatment tables and was annotated almost entirely in Japanese. Almost all of these objects were partially concealed by leaf and shadow. The waiting area was filled with a wide variety of plants and the lighting was always kept low. Many mornings when arriving at the clinic, I had to peer in through the glass front door to see if any lights were on. I often felt that I was playing at explorer, peering through a magic window into the darkness of a far-off jungle. From inside and veiled behind a large indoor ficus and the hanging branches of a rosemary-like plant, the grey stone goddess statue always stood seeming to look back past me, to the world beyond.

A typical patient arriving for their appointment at Clinton Street would step through the front doors into the waiting area. Directly in front of the waiting area was a large open reception window behind which was a desk where practitioners typically sat. If the client was early, they could sit on a couch or one of the few chairs. An office water

dispenser stood in plain sight for those who might be thirsty. Soft music usually played in the background. The acupuncturists would then meet the client in the waiting area and lead them to a treatment room. At Clinton Street, the treatment rooms varied in size and shape but each had a treatment table, at least one chair and a set of shelves or a stand for equipment. Once in the room, practitioners and clients would talk from as little as two minutes to as much as 15. The pattern of treatment after this initial conversation varied. Sometimes one set of needles were inserted for the whole treatment. Other times, Kirsten did one set of needles with the client lying face up and a second with them lying face down or included massage techniques or cupping in the treatment. After treatments, clients would return to the reception window to pay and schedule further appointments.¹⁹

Clinton Street accommodated multiple practitioners working independently. During my fieldwork, I followed several acupuncturists through the space and spoke with several massage therapists each of whom had their own business and managed their own clients and finances. Here I focus on Kristen, an acupuncturist and one of the founders of the clinic. Technically, the other practitioners worked as independent contractors for Kristen and her partner but this arrangement was made for simplicity sake, so as not to complicate the terms of their lease on the property. Where Green Leaf

¹⁹ This hypothetical “walkthrough” of Clinton Street can be compared with Green Leaf. Whereas Clinton Street had five individual treatment rooms, Green Leaf had a single room lined with two rows of four treatment chairs (8 total) that lined the far walls facing each other. Walking into Green Leaf for an appointment, a patient would first encounter a waiting area with a prominent front desk and practitioner just beyond it. Patients paid for treatment as soon as they entered the clinic and then let themselves into the treatment room to find an empty chair. The acupuncturist working that shift would then typically crouch or sit on a stool beside the patient, talk for five minutes or so and then insert needles. Much of Green Leaf was organized around what has come to be known as community-style acupuncture, a form of practice that does not use individual treatment rooms and keeps the costs of treatment as low as possible.

had been a private business owned by Emma, Clinton Street was fashioned as a shared space. In theory, each therapist had claim over certain rooms during set times, but in practice these conditions were flexible. Kristen was often involved in these transactions but generally refrained from exerting any special authority over them.

“We know how to move in this space—we know how to dance,” one of the massage therapists told me when I asked her about how practitioners worked together to manage changes in their schedules. Negotiation of clinical spaces involved both the navigation of a complex physical environment and the ongoing mediation of the needs of different practitioners. As with Green Leaf, there were risks and failures that came with this way of organizing practice. The ability to negotiate made the terms of operation flexible and responsive to the needs of the moment but it also required trust in fellow practitioners. Because so much of the organization of clinical activity relied on personal interaction, failures of trust could threaten the entire project. The same therapist who spoke to me of knowing how to dance would later leave Clinton Street for a variety of reasons including intractable disagreements with other practitioners about their use of the space. Unfortunately, her departure occurred after I had done the majority of fieldwork at Clinton Street so it is difficult to provide a more careful description.

Practitioners regularly arranged to swap rooms or times with each other in order to accommodate last-minute cancellations or re-bookings. Some of these negotiations happened in meetings convened every month or two but it was more common for it to happen at the beginning or end of a shift. The hub of these impromptu meetings was a

day planner just inside the threshold between the waiting area and a small office room with a front desk window where practitioners tended to congregate between clients. A large spiral-bound planner was always propped open on a bookstand on the desk. It served as an appointment book in which different practitioners could get a rough outline of each other's schedules. On each page, the corresponding working day was a collage of penciled in names (first names only or initials) and times punctuated by squiggles and the residue of erasures. Several practitioners also kept their own private appointment books. On a day when two or more practitioners had overlapping shifts, I could expect to see them occasionally hunched over the planner, adjusting the schedule for their convenience and that of their clients. The planner was as much a ledger to track the status of ongoing transactions as it was a blueprint of the impending day.

Each practitioner at Clinton Street was responsible for their own gear: needles, sharps containers, massage oils, etc. They brought and hung their own charts, pictures, and mirrors too. Through these objects, their influence could linger in the clinic long after they had ceased practicing there. Of the four acupuncturists who had founded the clinic, only Kristen still practiced out of the space but the material traces of each of the others remained. The large quilted dragon that hung in a treatment room came from one of these former residents. It was made for the clinic by his mother. Some of the photographs belonged to another. Several of the photographs were taken by Kristen and her partner, Jacinta (a massage practitioner in the clinic) during their travels. The stone statue by the front door came from a garden store that used to be right next to the clinic but went out of business. Kristen and a few of the other practitioners thought it

was more than worth the \$50 price so they bought it and “dragged it over” (the statue was solid stone and a lot heavier than it appeared). Many of the plants were gifted by patients in celebration of a practitioner’s birthday or in appreciation of treatment. One patient gave them a large decorative crystal and another an 8-foot tall Burmese temple rubbing from the 1930s bought at a local estate sale. When I asked Kristen if there was anything in the clinic that she did not like, she could only point out one object and say with a shrug, “its a shared space—everybody puts their things in it.”

In one of the treatment rooms, a pair of charts of the musculoskeletal system, an ink brush painted scroll of koi with poetic couplets, and a mirror hung side by side. The room itself was small. A treatment table took up most of the floor space and a tall client lying on the table could reach out and touch both walls. Let me consider for a moment the shared quality, intimacy, and distance between these objects in this space. The anatomical charts are highly indexed. Dozens upon dozens of bones and muscles are labeled with text that crowds around the images. The bodies are depicted anatomically standing completely upright with arms at each side. They are opened up and arranged so as to be “set in full light”²⁰ to borrow a phrase from Auerbach. Yet, they are far from passive receptacles of the gaze. The muscled body clenches its fists almost defiantly. Its eyes are locked in a hard stare. Whereas text and images fill the frame of these musculoskeletal charts, the hanging scroll contains mostly negative space. Almost a third of its surface is taken up by a plain purple-grey mounting. Paper is affixed to the

²⁰ Auerbach, Erich. 2003. *Mimesis: The representation of reality in Western literature*. Translated by Willard Trask. Princeton University Press. 6.

mounting and in its center are the silhouettes of two swimming koi (one red and one black) as seen from above. The koi are flanked by Chinese couplets that line up vertically with the edges of the scroll. To the right of the scroll hangs a small mirror framed by an abstract floral pattern with a pink hue.

Very little about the space of this treatment room indicates how one should conceive of the sharedness of these images. Physically they are proximate. Stylistically, they are miles apart. The musculoskeletal charts fit the standard conventions of anatomical representation in biomedicine. Their style stresses how parts of the body should be located, articulated, and distinguished from one another. Everything about the koi and the couplets draws on almost clichéd Chinese imagery meant to evoke a sense of playful tranquility. Its expressive mode is indirect and connotative especially for those unable to read cursive traditional Chinese script. Besides the almost kitschy frame, the mirror's visual dimensions are much more utilitarian. Patients used the mirror to put themselves back together from whatever state of undress was required by treatment.

The convergence of these three very different objects might be seen as a clear example of contemporary medical pluralism. Is this not a visual realization of that "random cannibalization of all the styles of the past, the play of random stylistic allusion" that Frederic Jameson calls pastiche and attributes to the logic of late capitalism?²¹ Perhaps. I was rarely able to observe treatments in this room because it was too small for me to stand in without significantly hindering the movement of

²¹ Jameson, Fredric. 1991. *Postmodernism, or, the cultural logic of late capitalism*. Duke University Press. 18.

others. It is possible that practitioners used these visual styles to cement their cultural authority over various forms of medicine. I would suggest however that, like Emma's clinic, the collected aesthetic did not strive towards an ideal design but crystallized a form of bricolage that should not be confused with pastiche²²—Bricolage being the play of materials at hand and pastiche the play of forms in allusion. The mirror and the koi painting belonged to one of the massage therapists and the musculoskeletal charts to another (Jacinta). These images helped them to establish their personal presence and comfort within a shared space.

Another fitting model of the kind of sharedness on display in the clinic could be found in Clinton Street's waiting area. One of the few books on the coffee table was *Unlikely Friendships*, a colorful series of short essays with accompanying pictures of friendships that have developed between different non-human species "who with nothing else in common, bond in the most unexpected ways."²³ One story tells of a cat that suddenly appears to be living in a black bear's cage at the Berlin zoo. The cat and the bear share food and spend more than a decade together. Another tells of a dove and a macaque who live in an animal protection station attached to the Futian National Nature Reserve. The dove seemed to have lost its mate and the macaque was a baby that sanctuary staff had discovered alone and weak while patrolling the island. The animals seemed to find mutual support during their recovery. Eventually, the bird flew

²² Here Claude Levi-Strauss' notion of premodern bricolage as working with a "heterogeneous repertoire" made up of "whatever is at hand" can be distinguished from Jameson's idea of postmodern pastiche. Levi-Strauss, Claude. 1966. *The savage mind*. University of Chicago Press. 16.

²³ Holland, Jennifer S. 2011. *Unlikely friendships: 47 remarkable stories from the animal kingdom*. Workman Publishing.

off and the macaque was successfully returned to its troop. In these stories, there are no consistent reasons for the coming together of different species other than happenstance.

A similar theme can be seen in the way Kristen engaged with the East Asian history and heritage of acupuncture. She was a strong proponent of Daoist and Buddhist self-cultivation practices and saw them as essential factors in the way she approached her work. Yet though we would talk about philosophical and historical aspects of the more spiritual side of Chinese medicine at length, I rarely heard her discuss them directly in the treatment room with patients. On the rare occasion that she would recommend breathing exercises or mindfulness practices, she presented them as simple techniques rather than ways of embodying cultural difference or awakening new systems of belief.

Kristen traveled to take seminars on classical Chinese medicine with practitioners like Jeffrey Yuan and Kiko Matsumoto. What distinguished these teachers for her was that they turn to classic texts and famous doctors for insights but do so while keeping in mind the needs of the present. Yuan and Matsumoto consistently emphasize that the classics are more useful in the way they can inspire new interpretations rather than conveying the tenets of a tradition. Kristin treated Chinese medicine as a collection of many distinct traditions each of which opened new ways of seeing. When we would talk about the technical theories or concepts of Chinese medicine, she was always careful to not confuse or syncretize the therapeutic approaches of, for example, Sun Simiao and Fu Qingzhu. The images adorning the walls of Kristen's clinic could similarly be collected under the sign of orientalism or

they could be distinguished with attention to both differences and mutual influences.

Somewhat coincidentally, the same clinical text that I found in Green Leaf (*The Psyche in Chinese Medicine*) showed up in Clinton Street one day. I asked Kristen where it came from and she wasn't sure. She guessed that one of the massage therapists might have brought it. As Kristen started to flip through the pages, I watched an amused grin spread across her face. "I don't even know what to do with this," she told me. The book seemed to disappear the next day and Kristen never brought it up again. Much as with Emma, evaluation of the text was not a question of authenticity or comprehensibility but of use. The important difference, however, was that the book was given to Emma as a gift from a patient and it was on these terms that it earned a place at Green Leaf. The book came into Clinton Street in the hands of one of its practitioners and over time remained more bound to that practitioner than to the space.

Not knowing one's place

In my thinking about the complex and often ambiguous patterns of belonging for objects and traditions in Clinton Street, I have been indebted to the work of Finbarr Flood²⁴ and Christine Mollier.²⁵ Their close examination of objects and places reveals how religious identities are forged internally but owe much of their unique character to

²⁴ Mollier, Christine. 2008. *Buddhism and Taoism face to face: Scripture, ritual, and iconographic exchange in medieval China*. University of Hawai'i Press.

²⁵ Flood, Finbarr. 2009. *Objects of translation: Material culture and medieval "Hindu-Muslim" encounter*. Princeton University Press.

the interface between distinctive and even opposing traditions. Mollier describes how Chinese Buddhism and Daoism shamelessly borrowed, appropriated, forged, rewrote, and reinterpreted each other's works. These texts often appeared in the form of "doubled" scriptures that could be claimed as both Daoist and Buddhist and resulted in bilateral "patterns of hybridization and influence linking the two religious traditions [as well as their] mutual implication in both scriptural and iconographic production."²⁶ Flood's inquiry into Hinduism and Islam follows various objects such as "coins, frescoes, modes of dress, texts, manuscripts, monumental architecture, and the more abstract but no less revealing realm of onomastics, royal titulature, and ritual practice"²⁷ and their circulation through and between supposedly fixed religious identities. Like Mollier, Flood looks beneath the visible antagonism between a foreign religion and its native counterpart to find patterns of mutual influence. Both Hinduism and Islam held the ambiguity of objects as a resource to be mined as much as a danger to be avoided.

Flood and Mollier each offer a powerful critique of the "clash of civilizations" model of exchange so promoted along the channels of modern cosmopolitanism. In the words of Flood, "people and things have been mixed up for a very long time, rarely conforming to the boundaries imposed on them by modern anthropologists and historians," an observation with which he rejects "any notion of a prelapsarian time when people knew their place."²⁸ Likewise, my ethnography of acupuncture rejects the notion of a time when objects in the acupuncture clinic knew theirs.

²⁶ Mollier, *Buddhism and Taoism*, 208.

²⁷ Flood, *Objects of translation*, 11.

²⁸ *Ibid*, 1.

Take, for instance, the gray stone statue veiled by leaves and standing by the front door of Clinton Street. Tracing its lineage turns out to be a complex task. My initial impression was of a generic devi, a Vedic figure with feminine and divine qualities. When I asked Kristen about the statue, she called it “Guanyin-esque”, which completely shifted the context of my interpretations. Associated with compassion and mercy, Guanyin is a font of religious healing throughout East Asian Buddhism. In part because of her status as a universal yet localizable figure, Guanyin’s position within Chinese spiritual geography is extraordinarily complicated. Historically, Guanyin enters East Asia as a translation of the bodhisattva Avalokitesvara and a kind of human metonym for the Lotus Sutra, which since its translation in the third century has been one of the regions most popular Buddhist scriptures. The name Guanyin is a shortening of Guanshiyin (觀世音), which is a translation of the Sanskrit name of Avalokitesvara. Guanshiyin means, more literally, “perceives the world’s sounds” but perhaps more accurately, “the one who hears the many sounds of suffering in the world.”

In the centuries since this translation, Guanyin has also taken on novel characteristics. In her extensive historical account of the subject, Chun-fang Yu describes Guanyin as a transformational character that straddles the distinction between the masculine and feminine, South and East Asia, and monastic and lay communities.²⁹ Yu shows how the goddess becomes increasingly feminized and sinicized by absorbing the characteristics of local goddesses and female archetypes: “through various myths and legends the Chinese managed to transform

²⁹ Yu, Chun-fang. 2001. *Kuan-yin: The Chinese transformation of Avalokitesvara*. Columbia University Press.

Avalokitesvara, the ahistorical bodhisattva who transcended temporal and spatial limitations as depicted in the Mahayana scriptures, into Kuanyin, who, known by different Chinese names, led lives in clearly definable times and locations on the soil of China.”³⁰ The dual valence of Guanyin as both completely foreign and completely native to China is further complicated by her effects on Taoist cosmology. As Mollier demonstrates, the figure of Jinku Tianzun is unquestionably Taoist yet “it is evident that his religious and iconic graphic properties [not to mention his ritual praxology] were patterned on Guanyin’s.”³¹ Jinku Tianzun was an attempt to undermine bodhisattva worship in China and was, therefore, a way to transform, oppose, and coopt Buddhist encroachment into the popular ritual practices of the region.

This history is relevant because it speaks directly to the blend of foreign and familiar so prevalent in Clinton Street. The Guanyin-esque character of the statue fits because it is the appropriation of an appropriation, a translation of a translation, the transformation of a figure that is itself a figure of transformation. These themes have always been linked to Avalokitesvara in his many forms: compassion for and attention to the myriad forms of suffering necessitates an expansive perspective and facility with self-transformation. Guanyin transforms to meet the needs of suffering, not to be comprehended.

Setting Avalokitesvara aside for the moment, we can also consider the circumstances that brought the statue into the clinic. The statue was not sought out by

³⁰ Yu, *Kuan-yin*, 295.

³¹ Mollier, *Buddhism and Taoism*, 207.

the practitioners or designed for use in a healing space but was purchased from a landscape and garden store that happened to be nearby and was offering an enormous discount because it was going out of business. The decision to bring the statue into Clinton Street was mediated by a price, one that Kristen had not forgotten (\$50) almost a decade later. That a monetary transaction was the basis on which the statue was moved into a place for which it was neither designed nor sought out to fill is related to its lingering status as a commodity.

In realization of yet another of the statue's aspects, I could also point out that the custom of garden stores selling goddess statuary has a long history connected with the idea of "the genius of the place," a notion that flourished in Italian renaissance landscape gardening and became foundational to the Anglo-American ideal of park and garden. The proper market for this statue would have been personal residential gardens whose lineage can be traced back to Roman notions of "genius loci," a statue that served as a center of worship by both presiding over and granting access to the spirit of a particular place. The Roman idea was disconnected from ritual and became the principle, famously articulated by the essayist Alexander Pope, that the design of a garden should not impose the will of the gardener but rather display the compatibility of the human spirit with a natural place. Whether through ritual or principle however, the goddess statues that populate so many American gardens are rooted in the desire not just to ornament a place but for a vessel through which to commune with one.

In writing about the different potential ways of emplacing or bringing meaning to the statue, I present an object that exemplifies an aesthetic permeated with a wide

range of possible interpretations. The exercise is not an attempt to uncover what Kristen meant by calling the statue Guanyin-esque or how other patients or practitioners interpreted it. I would not be surprised if Kristen was aware of much of this history based on the depth of her knowledge of Chinese Buddhism but my point remains the same even if she was unaware of it. I present her simple offhand comment as a provocation that could so easily upset my own assumptions about the statue and displace its heritage from South to East Asia. The journey from store to garden and clinic, from ancient Rome to the present-day United States, from commodity to spirit is in keeping with the idea that a bodhisattva of compassion and transformation can appear before the supplicant in the precise form that is needed. This is also in keeping with a broader aesthetic sensibility that values plasticity of meaning over its control.

Frames and fields

Kristen lived a short bike ride away from Clinton Street in a house that she shared with her partner and a housemate. She had a garden and a coop for chickens. One summer afternoon while walking through her yard and talking about acupuncture, Kristen made a point of showing me the two hives that she kept not far from her house. We stood enjoying the summer sun and watching the bees come and go from the small slit that served as the hive's opening. Kristen started talking about colony collapse disorder and how her experience with bees had taught her about acupuncture and healing.

Kristen: Most bees in mass production are pollinating just the almond crop, or just the clover crop, or whatever. So, they weren't getting a diverse amount of pollen and therefore they're not getting a lot of different kinds of propolis. It'd be like, you could survive if I just fed you bread but it's not healthy... These guys taught me a ton of stuff, Victor. When they have access to more diverse things, they seem to do better. The propolis is antiviral and antibacterial... When you have a regular hive, like, out in the bee field, there's these frames, right? And they put this premolded wax in there that they draw the comb off of. So, the premolded wax, they pick the size of the little bee cells but bees fill all different size cells. During the summer they make them a little bit smaller so you can have more worker bees. In winter, they make them a little bit bigger because they want the bees that survive through the winter to be bigger and hardier because they generate more heat that way. But, when you just determine the size for them, you're taking away their own natural innate knowledge. Like, they know what they're doing, right? And you force them to be a certain size. The other thing is that when you have part of that wax provided for them it doesn't have all the propolis and all that stuff that gives it all that antiviral and antibacterial quality.

Victor: And so there's also a root for other things to latch on to.

Kristen: Exactly. So this way, it's just like natural medicine, you're helping their innate knowledge of what they're doing. You're just giving them a space to do that in.

In sketching an ecology of pollen and propolis, flowers and hives, bees and beekeepers, Kristen offered a rich analogy for the clinical space of Clinton Street. In the idea of granting “access to more diverse things,” she might as well be speaking of how her clinic was furnished with multifaceted objects. In Kristen’s preferred method of beekeeping, the wax is a medium that can accept and carry a variety of substances. As I suggested, it could also be thought of as a place in which many different things could take root.

Just as the wax can serve as a model for clinical objects, Kirsten’s description of the frames of the beehive gives a sense of how she views clinical spaces. She talked about two different ways of configuring the space of the hive. The first way of framing works through predetermination. It uses the frame to set the size and shape of the cells in advance and attempts to approximate what bees are expected to need.

Predetermination, when done right, sees little change in the size of cells. The second way of framing instead *gives* space. The frame holds a space, which is then turned over to the bees to configure as they see fit. When framed openly, the cells might take on unexpected sizes. The openness of the frame does not provision or order the wax in advance but gives space and allows the wax to serve as a medium in which elements of the pollen field can be collected. To an extent, this shifts the space of production from the hive to the pollen field from which various materials can be harvested. Open framing is less predictable and requires careful attention, regular effort, and no small amount of restraint. Control over the hive can actively disrupt the rhythm of what

Kristen calls innate knowledge. The keeper thus puts their effort into the space, which then serves as a meeting point between the experiential skill of the beekeeper and the “innate knowledge” of the bees. Open framing is not an embrace of disorder or a reversal of the power dynamic between the bees and beekeeper. The beekeeper still has a measure of control and still takes honey. The frames are not radically open such that the bees control the keeper or that any configuration of the hive is possible.

In chapter 1, I described a scene in which Emma gave a very similar perspective on the importance of space in her practice of acupuncture. In the midst of a conversation between practitioners about their dissatisfaction with explanations for acupuncture, I had said that most acupuncturists are focused more on doing acupuncture than on explaining it. Emma replied in agreement, “we don’t do the work—we’re kind of like these nice people that hold this space for them. We do a lot of work to make this space safe [but] I don’t make your body do things.” For Emma, acupuncture enabled therapeutic change without affecting it directly. Many times, she described it as particularly efficacious because it didn’t ask or demand much from the patient in order to work.

Practitioners at Green Leaf and Clinton Street worked hard to keep the demands on their time and space from being transferred onto their patients. These clinics were busy places but none of the patients that I spoke with described feeling rushed or cramped. Patients almost all emphasized that their acupuncturists listened carefully to them and that they felt comfortable sharing a wide range of symptoms and concerns. In chapter 1 for instance, I relate how Greg saw this kind of listening as indicative of the

care that he received at Green Leaf. Greg felt comfortable telling Emma about his anxiety, a topic that he had been avoiding with other medical specialists. Patients like Greg often spoke of the acupuncture clinic as having a welcoming atmosphere in which practitioners and staff were “nice” and the space was “comfortable” but was otherwise difficult to specify. This vagueness at the level of general description seemed to enable different aspects of illness and healing to become concrete in acupuncture’s clinical space. Greg was able to report on his anxiety because he was confident that Emma would be open to different interpretations of it.

With this in mind, I return to the problem of vagueness and the fact that patients and practitioners seem unable to definitively locate therapeutic activities except to say that they involve a diverse range of actors and objects. There are two issues here which are related but should not be confused. One is the uncertainty of illness both in the knowledge that practitioners can have about it and in the nature of its experience as it unfolds over time. Images of disease can be vague or unstable because of ignorance or inexperience. No acupuncturist that I spoke with would deny this. In fact, as I describe in the first chapter, they embraced it.

On the other hand, what looks like a vagueness born of ignorance can also be a form of openness of interpretation that was intentionally maintained within the therapeutic process. For Kristen and Emma, acupuncture is not an activity that orders the body but more a way of affording space and time for, let us say, the innate knowledge of the body to reorder itself. A great conversationalist is not someone who lays out the terms of discourse ahead of time and speaks only with full knowledge of

how a dialog will unfold but is skilled in inciting, uncovering, and responding to the words of someone especially when they are struggling to articulate a point. Such a skill also falls under the province of the participant-observer and of ethnographic composition. My inquiry into the clinical spaces of Green Leaf and Clinton Street must, therefore, be reflexive. If I insisted on specifying something that they worked hard to leave open, I would fail to address the nature of their practices.

In my attempt to keep from writing over the openness of acupuncture, I am reminded of Renato Rosaldo's renunciation of the "common anthropological assumption that the greatest human import resides in the densest forest of symbols and that analytical detail, or 'cultural depth,' equals enhanced explanation of a culture, or 'cultural elaboration.'"³² The claim comes at a moment when Rosaldo is writing about two impossibly intertwined fields of intensity: the Ilongot practice of headhunting and the accidental death of his wife. The essay uses the concept of force to navigate emotional landscapes and avoid the disciplinary preference to "explicate culture through the gradual thickening of symbolic webs of meaning."³³

In a collection of poetry written to explore his wife's death, Rosaldo includes what he calls a manifesto for anthropoetry.³⁴ In it, Rosaldo expresses anxiety over his poetic compositions and what they might uncover: "the prospect was daunting, even some twenty-eight years after the fact... What would I find in the difficult to access

³² Rosaldo, Renato. 1993. "Grief and a headhunter's rage." In *Culture & Truth: The Remaking of Social Analysis: With a New Introduction*, 1-21. Beacon Press. 1.

³³ Rosaldo, "Grief and a headhunter's rage," 1.

³⁴ Rosaldo, Renato. 2013. *The day of Shelly's death: The poetry and ethnography of grief*. Duke University Press. 104.

recesses of memory?"³⁵ Having already explored the topic in prose more than a decade before, Rosaldo appreciates the power of poetry to probe the depths of memory. The reach of poetry is indirect and difficult to anticipate. Drawing on the scholar Jean-Jacques Lecercle, Rosaldo contends that "the material of poetry is not so much the raw event as the traces it leaves."³⁶ While I too see the potential of poetics as a mode of ethnographic description, my concerns are caught in the interplay between material and form where Rosaldo was more explicitly concerned with the expression of emotion.

Instead of Lecercle, I turn to the concept of poetics as it appears in the work of Heidegger and Bachelard. Poetics, for Heidegger, is rooted in Greek notions of *poiesis*, which he describes as a bringing into being. Heidegger says that poetics is a prominent part of endeavors like handcraft manufacture, art, and of course poetry each of which works creatively with a material. Poetics can be used to describe processes of self-transformation such as the "arising of something from out of itself" (*physis*), like the "the bursting of a blossom into bloom."³⁷ Heidegger contrasts the work of poetics with that of technology, which "sets upon" and challenges its object.

The work of the peasant does not challenge the soil of the field. In the sowing of the grain it places the seed in the keeping of the forces of growth and watches over its increase. But meanwhile even the cultivation of the field has come under the grip of another kind of setting-in-order, which sets upon [*stellt*] nature. It sets

³⁵ Rosaldo, *The day of Shelly's death*, 104.

³⁶ Rosaldo, *The day of Shelly's death*, 102.

³⁷ Heidegger, Martin. 1977. *The question concerning technology, and other essays*. Garland Publishing. 10.

upon it in the sense of challenging it. Agriculture is now the mechanized food industry. Air is now set upon to yield nitrogen, the earth to yield ore, ore to yield uranium, for example; uranium is set upon to yield atomic energy.³⁸

The difference between poetics and technology, as I read it, resembles that between openness and predetermination. Technology, for Heidegger, is a way of fixing an object within a conceptual framework³⁹ where poetics works more closely with the self-organizing processes that can be born out of material.

The notion of poetics that I take from Bachelard can be found in his inquiry into the “philosophy of poetry.” He is concerned with how poetic images can serve as cornerstones for the phenomenology of ordinary spaces. Poetics, he asserts, cannot be understood by looking for an underlying basis of interpretation because:

Whereas philosophical reflection applied to scientific thinking elaborated over a long period of time requires any new idea to become integrated in a body of tested ideas, even though this body of ideas be subjected to profound change by the new idea (as is the case in all the revolutions of contemporary science), the philosophy of poetry must acknowledge that the poetic act has no past, at least no recent past, in which its preparation and appearance could be followed.⁴⁰

³⁸ Ibid, 14.

³⁹ Here I gloss what Heidegger might describe as the “ordering” of an object by “enframing” it with respect to a system of “standing-reserves.” Heidegger is here, as always, a purveyor of neologisms and philosophically technical language.

⁴⁰ Bachelard, Gaston. 1994. *The poetics of space*. Translated by Maria Jolas. Beacon Press. xv.

Like Heidegger, Bachelard opposes the poetic with the scientific. In his claim that a search for an underlying basis for the poetic image dissolves appreciation of its effect, we can see another version of the need to keep the interpretive field open to novelty and the unexpected. Bachelard's poetics is not premised on the integration of a new image into a body of tested ideas that precedes the moment of encounter and will persist beyond it. If there is a similar poetics in acupuncture, to see it would require setting aside the idea that its practice takes place within a relatively stable framework of shared concepts and meanings awaiting specification. Instead, the poetic image resonates, reverberates, and repercusses; "a flicker of the soul is all that is needed."⁴¹ For Bachelard, "poetry is a soul inaugurating a form."⁴² What I have been calling openness corresponds to poetics here again. In openness and poetics, form is emergent. Under predetermined or objective approaches, forms are already there to be recognized or affected in the material.

The poetics of clinical space

Although the flower arrangements of Green Leaf could be seen in many ways, the routines that placed and replaced them were stable. They always sat on the small table in the center of the front room next to the hand sanitizer, earplugs, and ginger candies.

⁴¹ Bachelard, *The poetics of space*, xxii.

⁴² Ibid, xxii. Here Bachelard is citing Pierre-Jean Jouve.

New flowers appeared on Monday or Tuesday mornings when Sam came in for treatment. The relationship between Emma, Michael, and Sam became visible to me because I could imagine the dahlias and chrysanthemums as part of the same process even if I never saw Sam arranging or placing them. Likewise, at Clinton Street, I could count on the grey stone statue to greet me at the door regardless of which practitioners were there and whether I imagined it to be an artifact of East Asia religion or a commodity meant for use in English style landscape gardening.

To understand the therapeutic work of poetics that I outline here, it is essential to consider the materiality of flowers not just in terms of their physical or chemical makeup, nor of their smells, colors, or other sensory characteristics but how these and other qualities become available through the rhythms and reverberations that stabilize ongoing processes. Material, in this sense, is a substance in wait of a project while poetry is a way of arranging this material so as to make it available to a diverse range of projects. Such a poetics of space touches on what psychotherapist Donald Winnicott has called the “area of formlessness,” a place of return to “material [as it] is like before it is patterned and cut and shaped and put together.”⁴³ Flowers, either in their arrangements in Green Leaf or in the exudate producing clover for Kristen’s bees, attract attention that is renewed regularly. Fresh flowers on a gravestone gesture towards a loss while at the same time providing material testimony to the ongoing nature of social relations between the living and the dead. Flowers can evoke the fleeting quality of life but to notice that they are replaced before they can wither is to recognize a form of care

⁴³ Winnicott, Donald Woods. 2005. *Playing and reality*. Routledge. 45.

sustained in the face of an irreconcilable absence. Attention to these moments requires not penetrating insight on the part of the ethnographer but patience, restraint, and an eye for the way that certain details resonate.

My attention to the poetic is a way of listening for rhythms that are woven into the social fabric rather than a way of disclosing hidden meaning. Tim Ingold uses a similar approach in his analysis of the weaving of a basket:

[The basket] comes into being through the gradual unfolding of that field of forces set up through the active and sensuous engagement of practitioner and material. This field is neither internal to the material nor internal to the practitioner (hence external to the material); rather, it cuts across the emergent interface between them. Effectively, the form of the basket emerges through a pattern of skilled movement, and it is the rhythmic repetition of that movement that gives rise to the regularity of form.⁴⁴ ... The artefact, in short, is the crystallisation of activity within a relational field, its regularities of form embodying the regularities of movement that gave rise to it.⁴⁵

The clinical settings that I have described are likewise material arrangements that are patterned out of a social field.

One of the consequences of using flowers to understand acupuncture is a

⁴⁴ Ingold, Tim. 2002. *The perception of the environment: Essays on livelihood, dwelling and skill*. Taylor & Francis. 342.

⁴⁵ Ingold, *The perception of the environment*, 345.

repositioning of the basic divisions between biomedicine and Chinese medicine, scientific thinking and poetic reverberation. In the contemporary world, social scientific inquiry into acupuncture is typically arranged on either side of a fault line that separates “East” from “West” with the difference between these sides understood in terms of “ways of seeing” or “ways of knowing.” Historical and anthropological analysis has focused less on the question of where one looks than of where one looks from. Shigehisa Kuriyama summarizes this question elegantly: “we are apt here to speak vaguely of different ways of thinking, or more slyly, of alternative perspectives: witnesses to an event often disagree, and not because of any dishonesty or clouded judgment, but just because of where they stand.”⁴⁶ Foucault’s well-known analysis of the medical gaze proceeds in a similar vein. His archaeological approach attempts to unearth the historical foundations that support particular forms of medical perception.⁴⁷ One unfortunate consequence of the approaches taken by Kuriyama and Foucault is that they have left the body’s status as the proper site of medical inquiry uninterrogated.⁴⁸

My use of poetics is an attempt to avoid ruts in the road from East to West. Though the figure of Chinese philosophy is often used to understand acupuncture, I have tried to displace this commonly accepted framework by showing how thinkers like Heidegger and Blanchard resonate. The poetics of therapy is not isolated in one

⁴⁶ Kuriyama, Shigehisa. 2006. *The expressiveness of the body and the divergence of Greek and Chinese medicine*. Zone Books. 9.

⁴⁷ Foucault, *The birth of the clinic*.

⁴⁸ For Kuriyama, the in body is the central object of expressive and perceptive difference. One of the central problems that Foucault investigates is how “the human body [has come to define], by natural right, the space of origin and of distribution of disease.” Foucault, *The birth of the clinic*, 3.

particular culture or system of medicine, even if its presence in acupuncture more concentrated than other parts of the American healthcare system. I recall that day, sitting on a porch with the pediatrician friend of a friend, and how familiar he was with a medical sensibility that was supposed to be foreign. Acupuncture patients also rarely feel the need to adopt or even begin to comprehend a new set of medical concepts. Certainly, they can step into clinical spaces like Green Leaf and Clinton Street and focus on its unfamiliar or even exoticized elements as anthropologists are prone to do. In this chapter, however, I have tried to place such focused modes of aesthetic apprehension within a broader interpretive field. This move is made possible by an ethnography whose sustained attention to the materials that make up acupuncture therapy respects both their vague and concrete aspects to show how patients or practitioners pull such materials through openings in the fabric of relations and into a space of creative transformation. The poetic capacity of acupuncture to draw out and rework frameworks that have been folded into the body is part of what makes it effective in this time and this place of contemporary American society.

In the next chapter, I will redirect my analysis from clinical materials and spaces to expressions and experiences of illness. The concept of poetics will also shift slightly by emphasizing the poetic fragment over this chapter's focus on the poetic image. Furthermore, this chapter concerns how clinical encounters are "set up" while chapter 4 shows how meaning emerges out of them.

In closing, I must stress that acupuncture has historically been an eclectic practice constituted with respect to a tremendous diversity of styles and theories. My selection

of these particular clinics and these practitioners is not meant to be representative of acupuncture as a whole either in the United States or elsewhere. As is the case with many small business ventures, acupuncture practices are extraordinarily vulnerable to economic pressures and few are able to sustain themselves past the first few years. Green Leaf and Clinton Street have both been in business for over a decade and have not only survived but thrived. They have been supported by robust and committed patient populations that come from many backgrounds and walks of life. These facts support the idea that Green Leaf and Clinton Street are significant practices but do not make them broadly representative. This significance along with the multitude of vagaries that make my ethnographic fieldwork not so much a matter of choices as of fortunate accidents have led me to focus on these particular clinics over others.

Thus, my emphasis on poetics is not intended to encapsulate or even epitomize all of the many different acupuncture practices in the United States. I have no doubt that there are acupuncture practices built around presenting acupuncture as an exotic cultural experience or as a Chinese medical technology. The aim of this ethnography is not to speak *for* acupuncture but to speak *from* it in the hope that these ideas will reverberate with the experience of others like they did with that biomedical clinician. I present an image of the poetics of therapy as it occurs in these particular clinical settings without assuming which aspects of them can or cannot travel beyond.

Chapter 4

You cannot form the words:

Emergence, experience, and diagnostic expression in American acupuncture

“You could see in her face how much she’d been through. I saw her and I just wanted to go in the bathroom and cry.”

The recollection brings Emma to the verge of tears. We are drinking tea in her living room and talking about Jennifer, one of her former patients.¹ They had not seen each other in years, not since Emma had left her practice at Green Leaf Community Acupuncture to direct the teaching clinic of an acupuncture school on the other side of the country. I am sitting on her couch with her wiry-haired little dog curled up beside me. I mention that, despite the obvious intensity of her distress, Jennifer never had a name for what was wrong. Emma pauses for a second. She seems to be going back through the case in her mind. “What would you even diagnose her with? High trauma?” Emma asks rhetorically.

Several weeks later, I meet with Jennifer at a park near her mother’s house. Sitting side by side at a picnic table, we watch her daughter, Aisha, play. “My daughter insisted on wearing this,” Jennifer says, trying not to fret over Aisha or worry that she might trip over the hems of her floor-length gold dress. But the small child never seems hindered as she moves quickly but carefully across the playground. She makes friends

¹ Emma and I were limited in terms of who and what we can talk about. Jennifer was one of the patients who had permitted us to discuss their cases in this way.

quickly too. Occasionally she brings her new friends over and introduces them to us. When Aisha starts to linger nearby, Jennifer tells her that “we’re talking about adult things” and encourages her to go play elsewhere. “I’ll zip my mouth,” the child suggests but it is distance, not quietude that Jennifer seeks.

Jennifer tells me that she remembers Emma crying during their first appointment. Seeing her acupuncturist weep to hear her story made Jennifer realize just how much she had lost touch with her own feelings. “I had severe post-traumatic stress disorder and I had, like, no emotions for a good year—I was going through the motions,” she recalled.

Jennifer: When all of it’s happening to you, you just
I don’t want to say you accept it, but it’s happening and you don’t
name it
you don’t have the capacity to name things when they’re happening to you
you know very basic things like,
‘I am sad’ and ‘I don’t feel good’
and ‘I am hurt’
and you don’t even say them out loud
You just bear them within you, so, when you’re seeking out help
you just know that you need help
you do your best logically to say, like, ‘this is what happened to me’
but you cannot form the words like ‘yeah, I think I have post-traumatic stress

disorder’

As Jennifer speaks, I write the word “PTSD” in my notes and underline it. When I had observed her getting acupuncture and in the years since Emma had left, I never heard Jennifer offer anything like a diagnosis for her suffering. Instead, she had spoken explicitly about not being able to name what was wrong.

Jennifer’s adoption of the term is all the more striking in light of the fact that Emma, a practitioner who had taught courses on ‘trauma-informed care,’ favored the ad hoc phrase “high trauma.” In the course of my fieldwork, I had spoken with Emma extensively about the nuances of PTSD. As a licensed acupuncturist, Emma could not formally diagnose PTSD but I had heard her suggest it to her patients as a possible condition a number of times.

Curious about where the diagnosis had come from, I ask Jennifer, “you said it was recently that you started to put this together as PTSD—how did that happen?” There is a lyrical quality in the way that she answers, her words flowing and turning like the bend in a stream.

Jennifer: I have a friend that’s like really good at labeling people that she feels
might have medical things.
and she just said it
and I recall one of my friends telling me
she was like, ‘you know after you had your daughter, you were like a robot for

like a year? You had like, no personality'
you don't have time for reflection or you don't have time for
I would even say
you don't have time to be kind to yourself
when you're in survival
I went to Green Leaf because it was *necessity*
it was necessity that I survive
self-reflection is a gift
to the few that can afford it.
and if you're in a place where you can self-reflect it means
that you're not in the middle of a war zone
not in the actual middle of trauma.
I guess that's why it's happening now
that's why I can give myself names of things
that's why I can say, 'wait that's PTSD.'
as opposed to like
stepping out of your trauma and stepping out of your guilt
and your perpetual shame
is when you can have these moments of clarity.

The designation of PTSD was not conferred by a healthcare provider nor had Jennifer brought the diagnosis to a medical institution to be recognized or authorized. PTSD was

a name that she accepted for herself after having been given the label from a friend. The term describes a recognizable state of disease or disorder but it is also a personal reflection that allows her to locate traumatic experience and its intimate effects on her sense of self. I hear these words as being spoken through what Cathy Caruth calls a language of play and creativity that begins “as an act that bears witness to the past even by turning from it.”²

Although the diagnostic term itself does not come from her acupuncturist, the clinical encounter between Jennifer and Emma has a role in its appearance. In the encounter, Jennifer catches her own reflection in Emma’s tears. The emotional exchange between them allows Jennifer to recognize her trauma even though the name would not come until much later. In the meeting and its aftermath, there is an inversion in the roles of patient and practitioner as commonly conceived with respect to diagnosis. It is the body of the practitioner, not the patient that produces an objective sign of the malady. It is, furthermore, the patient who ultimately reframes her disorder using the technical language of medicine while the practitioner resists fitting the illness experience to a formal diagnostic category.

In the last chapter, I examined how clinical materials are made available for the work of therapy. That chapter used poetics as a framework for understanding acupuncture as an open and creative activity. This chapter makes a similar argument with respect to diagnostic terms. The chapter is organized around the cases of two

² Caruth, Cathy. 2001. “Parting words: Trauma, silence and survival.” *Journal for Cultural Research*. 5 (1). 7-26. 14.

acupuncture patients: Alice and Jennifer. These cases are built using a variety of source material including fieldwork in acupuncture clinics, conversations and interviews, observation of treatments, and examination of medical charts. The premise of this chapter is partially inspired by Jennifer's explanation for why she did not initially give her suffering the name PTSD. Her specific turn of phrase, "you cannot form the words" has led me to wonder where this failure to form takes place. Is it in the throat, on the tongue, in the mind, in hope or desire, or in the conditions and histories of the life that surrounds her? What prepares her to later take these diagnostic words as her own?

Besides investigating how patients formulate diagnoses in the context of their own lives, diagnostic terms can also reveal aspects of how the therapeutic activity of acupuncture is understood by its patients. The use and absence of these terms can give a sense of how patients participate in acupuncture, how they experience its effects, and how they understand the ways in which acupuncture is embedded in the institutions and frameworks of biomedicine. Here I imagine the role of the patient as involving more than just seeking care and consenting to treatment. Active patient participation has been a vital component of acupuncture in the United States, which owed its resurgence since the 1970s as much to popular demand as to established medical institutions. Joseph Kotarba, in ethnographic work with a small number of both physician and "folk" acupuncturists in the United States in the early 1970s, calls these practitioners "entrepreneurs of hope."³ He shows how, in a medical marketplace

³ Kotarba, Joseph A. 1975. "American acupuncturists: The new entrepreneurs of hope." *Urban Life* 4 (2): 149-177.

otherwise monopolized by biomedical ideologies, acupuncture's professional status was deeply tied to patient aspirations. In this context, acupuncture was portrayed not as "a marginal or 'devious' form of health care" but as a practice whose "popularity has increasingly grown for physicians and patients alike as they perceive acupuncture as representing a meaningful response to one's life circumstances."⁴ Though many of Kotarba's observations on acupuncture are specific to that moment in history, the idea of it being seen as a meaningful response to a patient's life circumstances remains extremely pertinent.

How exactly does acupuncture respond to life circumstances in this day and age? The concept of medical relativism gives a straightforward answer to this question, namely that acupuncture's response is characterized by East Asian concepts of disease and the ways in which it is translated into American contexts. Medical pluralism frames acupuncture as offering different concepts and therapeutic interventions than what is expected from biomedicine.

However, even the slightest attention to the cases and narratives of acupuncture patients reveals that this distinction between biomedical and Chinese medical registers is not as meaningful for patients as it might otherwise seem. None of the 28 patients that I interviewed focused on the diagnostic terms of Chinese medicine to identify their understanding of acupuncture practice or their reasons for using it. Yet, they were not nearly as shy when it came to biomedical terms. Often their use of acupuncture was in specific response to a biomedical diagnosis or, almost as often, a lack of one. A patient

⁴ Kotarba, "American acupuncturists," 173.

with back pain would often be able to associate it with, say, a disc herniation at L4-L5 but was rarely able to speak to Chinese medical diagnostic patterns such as Kidney yang deficiency, qi and blood stagnation, or qi deficiency that their acupuncturists might have used. I also rarely heard practitioners using Chinese medical terms in their conversations with patients or in advertisements for the practice.

As I described in chapter three, these findings are consistent with those of scholars like Claire Cassidy and Sylvia Schroer. Cassidy, in her review of “460 handwritten stories collected as part of a mixed quantitative-qualitative survey of 6 acupuncture clinics in 5 states,”⁵ found only 7 instances in which people used language associated with Chinese medicine. Her data “generally suggest that the theory of Chinese medicine per se was either unknown or irrelevant to these respondents.”⁶ Likewise, in in-depth interviews conducted with 15 patients of a British acupuncture clinic, Schroer found that “patients rarely used Chinese medical language.”⁷ This is not to say that there are absolutely no acupuncturists who are conspicuous in their use of Chinese medical terms in interactions with patients or patients who are aware of them but that this approach was not at all characteristic of American acupuncture practice.

What features do characterize acupuncture’s diagnostic approach? Holism and emergence are two terms in the clinical research literature that come up frequently in this regard, particularly in the work of Cassidy and Charlotte Paterson.^{8,9,10} Paterson and

⁵ Cassidy, Claire Monod. 1998. “Chinese medicine users in the United States part II: Preferred aspects of care.” *The Journal of Alternative & Complementary Medicine*, 4 (2), 189–202. 189.

⁶ Ibid, 200.

⁷ Schroer, Sylvia. 2005. “Patients' explanatory models of acupuncture.” *European Journal of Oriental Medicine*, 5(1), 34–43. 44.

⁸ Paterson, Charlotte, and Nicky Britten. 2004. “Acupuncture as a complex intervention: A holistic model.”

Dieppe write, for instance, of “the emergent nature of Chinese diagnoses.”¹¹ Cassidy writes that holism “implies an emphasis on the *whole* or complete organism (as opposed to reductionism), and to the sense that this whole is *emergent*, or more than the sum of its parts.”¹² In this chapter, I focus on emergence as it applies to the use of diagnostic terms by exploring the difference between what Asif Agha¹³ calls the emergent and stereotypical features of language. Stated succinctly, stereotypic features are those that are stabilized within particular groups of language users and across many uses of the term. Emergent aspects, on the other hand, arise only with respect to the specific circumstances of each use: “no socially widespread scheme... underlies the construal.”¹⁴ Medical pluralism, by focusing on differences between the stereotypic features of biomedical and Chinese medical diagnostic terms misses the relative value that acupuncture places on their emergent features. As the chapter develops, I will argue that American acupuncture cultivates the emergent features of diagnostic terms to better respond to the lives of patients. Many patients find this kind of attention effective because it reflects their own struggle between the uniqueness and sharedness of their illness experience.

Journal of Alternative & Complementary Medicine 10 (5): 791–801.

⁹ Paterson, Charlotte, and Nicky Britten. 2008. “The patient’s experience of holistic care: Insights from acupuncture research.” *Chronic Illness* 4 (4): 264–277.

¹⁰ Paterson, Charlotte, and Paul Dieppe. 2005. “Characteristic and incidental (placebo) effects in complex interventions such as acupuncture.” *BMJ* 330 (7501): 1202–1205.

¹¹ Paterson and Dieppe, “Characteristic and incidental (placebo) effects,” 1203.

¹² Cassidy, “Chinese medicine users in the United States,” 193.

¹³ Agha, Asif. 2006. *Language and social relations*. Cambridge University Press.

¹⁴ Agha, *Language and social relations*, 16.

Case 1: Alice

From back to head and back again

When Alice started getting acupuncture treatments it was for two specific ailments: tendonitis in her forearm (and the pain associated with it) and pain in her back. Then in November of 2014, several years after she started using acupuncture, Alice told me that she now used acupuncture for what she called “head struggles”—an open-ended term that included very different kinds of afflictions.

Alice: I realized pretty early on in the summer or in June [of 2014], that part of what acupuncture was doing for me was giving me headspace. Every time I was going for my back, it would help tremendously but it was a place to be completely calm and serene and have nothing but what was in my head or nothing going on. I never ever, ever, ever, ever in my life carved time out to actually practice [making space to collect my thoughts and calm my brain].¹⁵ And, I believe that’s part of what acupuncture was doing.

During fieldwork, I heard many versions of this story especially among patients who were receiving acupuncture regularly. Initially, they sought acupuncture to alleviate a particular symptom or in association with a specific diagnosis but, over time, they used

¹⁵ In the bracketed section, I have taken phrases from earlier in our conversation that I believe Alice was referencing. What she actually says is “carved time out to actually practice that.”

it to achieve general effects described in more personal terms. Patients might say, “it just makes me feel better,” or “it puts my mind at ease.” Alice was fond of saying, “it gives me peace of mind.” Like many patients, Alice had come to acupuncture with no commitment to either counter-culture values or East Asian philosophies. It was her experience of acupuncture and its ability to ease her head struggles that led Alice to read about practices like Zen Buddhism, not the other way around.

However, the narrative arc that leads from tendonitis and back pain to head struggles started to dissolve when we went over the details of individual appointments and their frequency. Alice told me that she had been going to acupuncture almost twice a week for about eight months when she found out that she was pregnant. Her acupuncturist was very excited for her but said that her pregnancy would prevent them from treating her back pain. As a result, Alice significantly decreased the frequency of treatment from twice a week to less than twice a month. While telling me this, she immediately realized the contradiction, admitting that it was “sort of ironic because I’m telling you that [my use of acupuncture] was mostly a mental space thing” yet her choices about when to get acupuncture and what to get it for were much more consistent with the idea that she used it primarily to treat her back.

The begets

Alice is an extraordinarily productive person always engaged in some new project. She

is an IT project manager by profession, a job that depends almost entirely upon her ability to juggle the demands of people, deadlines, and ongoing projects. Alice has been promoted from an assistant software engineer through the ranks and across organizations to the point where she heads a large IT department at a well-known publishing organization. Alice's aptitude and desire to plan and accomplish projects is as evident at home as it is on the job. She sews and knits almost every day. For a time she managed the plots at a local community garden while tending to the vegetables in her own plot. There are binoculars on her window sill for bird watching and she keeps track of the movement and nesting patterns of local birds. When Alice cooks, she tends to return to the same recipe over weeks or months until she feels that she has perfected it. She seems to find deep satisfaction in not only getting things done but in getting them done artfully.

For about 10 years, Alice lived in a large East Coast city in a row-home that she owned with her husband. It is the city in which she was born. When Alice was young, her family moved to a much more suburban and rural setting. She returned to the city for college and afterward transitioned into professional life without leaving. The neighborhood where she lives is a mix of working and middle-class residents, young professionals, and older homeowners. The area grew in the early 20th century largely in step with the city's industries. A series of successive migrations brought immigrants from southern Europe and black Americans from the South, and more recently a wave of immigration from Southeast Asia, Mexico, and Central America. It was not unusual to hear three different non-English languages spoken on the streets around Alice's

house. Alice knew almost all of the neighbors on her block.

Alice met her husband while taking a class in her spare time. They hit it off very quickly and were soon married, moved in together, bought a house, adopted two dogs, and more recently began to think about having children. As she explained it to me, Alice began to realize that she was 37 and so needed to start thinking about having kids sooner rather than later.

In late spring of 2011, Alice told her primary care provider (PCP) about neck pain that she had been having on and off for several months. Her PCP referred her to an ear nose and throat specialist (ENT) who, after an examination, suggested that she had a form of temporomandibular disorder (TMD). Because of the pain's persistence, Alice would refer to it sarcastically as "neck cancer" with a colleague at work, which she knew at the time was a bad joke.

Two years after the first ENT visit (the summer of 2013), Alice brought the issue up again with the nurse practitioner at her primary care clinic who was dismayed that the pain had not changed. She referred Alice to a different ENT who checked her sinuses and had an audiologist examine her hearing but no problems were found. This second ENT also suspected that the problem was TMD. When Alice told him that she was confused about how TMD could cause her neck pain and about the ongoing failure to locate the problem, he recommended a CT scan to image her neck and head "just to be safe." She got the scan, which detected no problem with her head or neck but inadvertently imaged a nodule in the upper portion of her lung. A second set of scans imaged her lungs and Alice met with a pulmonologist who told her that "he didn't like

the raw edges” and “it didn’t look enough like scar tissue” for his liking. He told her that there was a 50 percent chance that she had lung cancer. He recommended that she have another set of scans three months later to see if the mass had changed or grown. This was September and October of 2013.

Alice returned to her PCP, who suggested that she meet with a surgeon right away to learn about her options in the case that the nodule turned out to be cancer. The surgeon gave Alice what she calls a “more aggressive recommendation.” The growth was too small to biopsy so he suggested that if it grew or remained unchanged in the second scan that they would “go get it and find out what it is.” Alice and her husband remained skeptical of this approach but began to think more seriously of surgery in the months spent waiting for the second set of scans. In the meantime, Alice discussed her neck pain (the initial symptom which led her into this diagnostic network) at an appointment with her primary care provider. They came to the mutual decision that without a clear plan for assessing her neck pain and with the looming threat of cancer they would not pursue further diagnosis.

During all of this time, Alice had been getting acupuncture treatments. Just before the nodule was found in her lung, Alice also started taking yoga classes at the recommendation of a friend. She told me that yoga appealed to her because it was a “playful” form of exercise. She wanted to get stronger and healthier but not get yelled at by an instructor. She had tried swimming but even though it was fun, she preferred the camaraderie and interpersonal aspects of yoga classes. She associated her use of yoga with acupuncture such that they became distinct parts of a related project.

The first week in December (of 2013), Alice had her second scan. She called the pulmonologist's office regularly for two weeks after the scan but was told that he was unavailable. She told me that she felt like she spent her days "waiting waiting waiting for the damn pulmonologist to get back to me." Three days after the scan, her surgeon called and told her that her new lung image showed no change in the nodule. Contradicting his earlier suggestion, he recommended against surgery because it would be "too aggressive." Alice found his advice comforting and a week or so later when she met with the pulmonologist he concurred and recommended a third scan be performed six months later.

Alice slowly let friends and family members know about the possibility that she might have lung cancer. She and her husband broke the news to some friends at brunch one week. "We knew they had something to tell us when they invited us," one friend told me, "I thought it would be that Alice was pregnant." This friend happened to work in the clinic of a prominent cancer specialist at a nearby university hospital and recommended a clinic where they could get a second opinion. Through all of this, Alice and her husband were still thinking seriously about having kids. She told me that by the end of 2013 that she had decided that she was "either going to have a baby or a lung surgery next year." Her and her husband both told me that they felt at this time like surgery was only weeks away.

Alice made an appointment to see the lung cancer specialist her friend recommended in January, which was his earliest availability. Her impression, at least in hindsight, was that he was very thorough. She went to the appointment with her

husband (they went to most of these appointments together). They were asked a range of questions about her family medical history, her own general health history, and environmental information. They appreciated that he examined the images of her lungs without looking at the radiology reports beforehand because it indicated that he wanted to make up his own mind about the evidence. Alice said that he concluded his assessment by telling her:

Alice: I think you have a case of the begets. This test begets another, which begets another. Cancer never gets smaller but it looks like this is. Stop getting scans. You need to just live your life and we'll get a scan again in 18 months. Start a family. Do whatever you want. I hope the next time I see you, you have a toddler or whatever. We had told him that we had been thinking of starting a family last year and then it kind of got put on hold.

It was at this point that what once was seen as potential cancer began to become a "cancer scare," a glance at an object seen through the rearview mirror rather than anxiety over a possible future.

Piecing together

Privately, Alice's friend heard through a doctor who worked with Alice's cancer

specialist that he didn't find any indication that she had cancer and joked that she could start smoking again if she wanted. Alice was reassured by the cancer specialist but the stress of a possible cancer diagnosis combined with the pressure of work and home life started to overwhelm her.

Alice: I had been on vacation for two straight weeks and was going back to work and realized I don't feel any happier or more at peace than when I left. I was upset and tangled up emotionally with a number of people in my life. So like right there and then I opened my laptop and made an acupuncture appointment for two days that week. I was just like, 'That's it. I'm going to acupuncture. If everybody else around me is going to do what they want and view what I'm doing as selfish, [then] fuck it. I'm going to take care of myself too.' So, I booked two acupuncture appointments and I just started this regimen for myself. I was going to yoga at that point like anywhere from two to four times a week and I was going to acupuncture two times a week and it was amazing. I tried to completely fill up more of my personal time with things that made me feel a lot better.

It became difficult to dissociate Alice's use of yoga from acupuncture at this time though they seem to fulfill different functions. Yoga was meant to promote strength, mindfulness, and health. Acupuncture seemed to work both to promote a general sense of well-being and as an instrumental therapy to alleviate specific symptoms. What

emerges is less a moment of transition from using it for a specific illness to using it for general wellness than a series of false starts depending on when and how the question is asked. Speaking with Alice in February of 2017, she placed the transition definitively within the period of her cancer scare:

Alice: I was feeling worse and worse. I realized three or four weeks in that if I didn't start trying to deal with my mental health that my brain would actually make me sick faster than anything that was in my lung would. That's when I went to my first yoga class and then I started to go to acupuncture more regularly.

But, within minutes of that statement she changed her mind saying:

Alice: I feel like I wouldn't have just decided to go to acupuncture for stress. I feel like I had to have had been going for something else and just realized that it made me feel better. Even, it may have been in [our November 2014 interview] that I started to really piece together how much I had relied on it for stress relief back then. More than anything, I was going for the back pain and the tendonitis pain because the tendonitis was pretty awful. I couldn't sit at my desk comfortably. I couldn't work comfortably.

The pattern is nearly identical to the one that occurred in an earlier interview in which

Alice identified the moment of transition as January of 2014 before moving it to the summer and then realizing that she had used acupuncture as it were a specific treatment for back pain until as late as September. The plot does not run smooth but is constantly tracking forward and backward and across the temporalities of family, professional, and other aspects of life.

In January of 2014, Alice began making entries in a small book bound in brown leather with unlined pages. The first date listed is “Jan 6” but there is no entry after the dash. The next date, Jan 10, begins:

Should this be a smaller collection of days ahead, I believe delibrance is in order.

Not so much a resolution. Just a new thoughtfulness. Here we go.

This was after Alice’s second lung scan but before she had an appointment with her lung specialist. In 2016, when I had asked Alice for details about her use of acupuncture during that time, she told me about the journal and offered to share it with me. She told me that it was a way to keep track of various things including her health and her wellness regime. I wasn’t sure what to expect when I read it. I was hoping for descriptions of aspects of her acupuncture appointments and the feelings that she associated with them.

On a Sunday in late January, she writes, “my back pain grew increasingly worse all week... it is now terrible pain.” A week later she scribbles in a note, “my acupuncturist attacked my back on Friday the week before and again on Monday. By

Wed I was feeling almost 90%! It was great to be able to tie my shoes w/o excruciating pain.” But, there are few other notes of this kind. In the middle of February, Alice writes, “generally, it was a very hectic week at the office ~~and~~ but I went to acupuncture and yoga once mid-week. This tends to keep me doing well.”

There are descriptive passages in which Alice writes about her stress at work, various projects, the weather, the death of family members, trips, weddings, and visits from old friends. The journal ends with a series of entries written just after the birth of her daughter. Her prose in those two sections makes up by far the most coherent narrative of the text. Otherwise, the majority of the book is a series of dated lists that Alice uses to log the kinds of things that she has been eating, the exercises she does, the quality of her sleep, and practices like acupuncture and yoga without much elaboration. One page is dedicated to the question of whether investments should be used to pay off her mortgage. It consists of a list of assets and a second for “exploring options.”

Analysis of Alice’s case: Reading cancer

In Alice’s case, diagnostic terms move between jokes with coworkers and brunch meetings with friends, husbands and doctors, diaries and medical reports, bodily experiences of pain and acupuncture, forms and fragments. Diagnoses interact, compete, and coordinate the way that she approaches her healthcare providers and how they treat her. The terms include cancer, tendonitis, and TMD and others like head

struggles, back pain, and the begets. As soon as cancer enters the story, it begins to organize the others. Even the possibility of cancer mobilizes a range of medical diagnostics and potential interventions.

Let me consider then, different ways of thinking about cancer and the kinds of problems that each raises. First, we can think about cancer in the way that Alice does when she thinks through visits with healthcare providers. Here the central question is whether or not Alice has cancer. The surgeon, pulmonologist, and cancer specialist all use slightly different criteria to make this decision. Alice juggles these different criteria for herself. It is important to note that though the potential of a cancer diagnosis has powerful effects in and of itself, Alice is not merely an object of scrutiny. She is an active participant who shapes the course of the diagnostic process such as when she first points out that her differential diagnosis of TMD does not make sense to her. However, these differences in advice and interpretation should not detract from a shared sense that the ontological status of cancer is not beholden to the conventions used to name and recognize it. Simply following the criteria for determining whether a nodule is cancerous or non-cancerous does not make it so.¹⁶

The potential of a cancer diagnosis activates a range of social and institutional mechanisms. A false-positive diagnosis or an unsubstantiated assessment of cancer risk

¹⁶ Of course, social scientific analysis need not agree with this way of recognizing the ontology of cancer. Annemarie Mol, for instance, lays out a theory of disease ontology in which the diagnostic work of each medical practitioner enacts a version of a disease that must be coordinated with the others in order to be stabilized. Calling a nodule ‘cancer’ in the context of an array of other diagnostic practices does make a form of cancer which then must be coordinated with other forms. My attention, however, is focused more on the ethnographic problem of how cancer is recognized within Alice’s case, not on Mol’s philosophical concern about the kinds of theories that might conceptualize its being differently. Mol, Annemarie. 2002. *The body multiple: Ontology in medical practice*. Duke University.

confers a very real status and has very real effects. This is the danger of the iatrogenic disease that Alice's cancer specialist calls "the begets." The capacity of cancer to organize a medical narrative was detectable in Alice's way of telling her story. During our conversations, there was a discernible change when she would launch into the story of her cancer (later of her cancer scare). The narrative would narrow focusing in on how her various healthcare appointments gave or withheld information about her cancer: the 50/50 diagnosis from her pulmonologist, her frustration around receiving prompt interpretations of her scans, and the relief she felt after visiting the lung cancer specialist.

Then there are the more personal and circumstantial aspects of how Alice's image of cancer unfolds. Her professional life, affinity for personal projects, desire to have a child, the nature of her relationships with her various healthcare providers, the various illness experiences that she navigates, and the diagnoses associated with them all have a hand in shaping how she manages the threat of cancer. Alice's half-joking comment that she was "either going to have a baby or a lung surgery next year" would make little sense as a response to her ongoing diagnostic process without some grounding in these contexts. Even the idea that what I am writing about is a cancer scare rather than an early stage or precancer is a result of a particular set of circumstances that unfolded between October of 2013 and January of 2014 that could have turned out very differently.

These different readings of cancer can be understood in terms of Asif Agha's

distinction between natural, stereotypic, and emergent ways of reading.¹⁷ A naturalized reading of cancer evaluates it as a thing “in nature, outside the domain of culture and history”¹⁸ that can ideally be read so that “questions of its arbitrariness or conventionality no longer arise.”¹⁹ Stereotypical readings, on the other hand, see cancer through more or less widespread agreements about the terms of its recognition. Naturalized and stereotypic readings are not mutually exclusive but work alongside one another as the conditions of Alice’s cancer scare progressed. The mutual coordination of these readings is both a result of biomedical activities and a way of marking²⁰ particular activities as biomedical. A lung cancer specialist, a pulmonologist, and a patient like Alice need not agree exactly on what cancer is in order to agree that it is an entity that exists outside of culture and is best recognized within medicine.²¹ Emergent readings work differently. The emergent aspects of the use of a term take shape through the specific circumstances of its production and in the context of a unique constellation of other signs. Emergent readings involve “an intersubjective grasp of the attribution” that “depends on mutual orientation to a structure of information that unfolds while the sign-configuration is in play, not on conventions known in advance”²² or, to an extent, developed afterward. These three modes of reading cancer also provide models for approaching the formation of a cancer diagnosis: diagnoses can

¹⁷ This approach is premised on imagining cancer as an emblem, which Agha describes as a sign that “reveals properties or qualities... of the one contextually linked to it” Agha, *Language and social relations*, 257.

¹⁸ Ibid, 242.

¹⁹ Ibid, 258.

²⁰ The more accurate term with respect to language use in Agha’s framework would be “enregistering.”

²¹ Mol’s notion of multiple ontologies produced by diverse enactments is, under Agha’s approach, a matter of “fractional congruence” of a sign.

²² Ibid, 258.

be formulated as reflections of natural processes, through criteria that are widely agreed upon, and/or as unfolding only in the midst of a particular set of circumstances.

The difference is particularly insightful when applied to the way that Alice talks about her use of acupuncture. For Alice, acupuncture does not have its own set of diagnostic terms to be read either naturalistically or stereotypically. This is not a phenomenon produced by omission on my part. When talking about her acupuncture treatments, Alice either used terms that overlapped with biomedicine (like tendonitis) or used ideas like “head struggles” or that her “brain” was making her sick. Alice never mentioned concepts like “qi” or diagnostic phrases like “qi and blood stagnation” that one might expect if Alice understood acupuncture strictly as either a medical specialty within the institutions of American medicine or an alternative medical system with its own unique diagnostic terminology. Instead, acupuncture seems to be a place in which different diagnostic processes are not premised on either naturalized or stereotypical readings of disease but instead produced emergent readings.

The narrative arc in which Alice goes from tendonitis and back pain to head struggles may be signaling not a change in her reasons for using acupuncture so much as a gradual transition in her model of acupuncture from one that addresses specific disease concepts to one that values emergent descriptions and play. It may be that this way of seeing acupuncture is merely a quirk of Alice’s case and the way that she tells her story. When read in conjunction with earlier chapters on not-knowing and clinical spaces however, the pattern seems much more consistent. This emphasis on emergent readings also fits with the nonspecificity of ideas like holism, balance, energy, and

“treating the person, not the disease” that are extraordinarily prevalent in American acupuncture practice.

For Cassidy,²³ Paterson and Dieppe,²⁴ and others, the value of emergence in American acupuncture can be attributed to the holistic principles of Chinese medical theory. It is worth considering however the ways in which different approaches to diagnosis are not just a result of differences between biomedicine and Chinese medicine but also in differences within biomedicine itself. For instance, Julie Livingston in her ethnographic exploration of cancer in Botswana²⁵ describes a similar tension between emergence, stereotype, and naturalization. Critiquing the tendency to see diagnostic categories as names for universal pathophysiological realities, Livingston argues that cancer must also be seen as “something that happens between people”²⁶ and is thereby embedded in a social and cultural context and the unique circumstances of each individual diagnosis. Livingston demonstrates how “language, technoscientific practice, and embodied experience” merge “to create the particularities of cancer in Botswana, as distinct from and yet part of the global experience of the disease.”²⁷ The gap between cancer in Botswana and its imagined ideal is bridged by forms of improvisation in which doctors, patients, nurses, and relatives tailor globalized forms of knowledge to fit with the local conditions of clinical care.²⁸

²³ Cassidy, “Chinese medicine users in the United States part II.”

²⁴ Paterson and Dieppe, “Characteristic and incidental (placebo) effects.”

²⁵ Livingston, Julie. 2012. *Improvising medicine: An African oncology ward in an emerging cancer epidemic*. Duke University Press.

²⁶ Livingston, *Improvising medicine*, 6.

²⁷ *Ibid*, 84.

²⁸ *Ibid*, 6.

The question left unasked in Livingston but incredibly important in this chapter is how and why particular activities are thought of as biomedical. Why, for instance, does it make sense for Livingston to claim that improvisation is a “defining feature of *biomedicine* in Africa”²⁹ rather than seeing it as a reflection of broader styles of social relation of which the clinical encounter is but one manifestation? This question does not concern what Livingston calls the “embeddedness” of biomedicine in Africa but rather the embeddedness of cancer in biomedicine. When is it fair to assume that cancer is a medical concept and not a religious, economic, political, or legal one? Answering these kinds of questions might help to explain how cancer risk can get a patient caught in the current of a medically oriented process: “as any patient (not only in Botswana) will tell you, a cancer diagnosis hurls one into a therapeutic pipeline at great speed.”³⁰ The profound effects of the medical management of cancer are tied to whether and how a diagnosis of cancer is made legitimate within medicine, which in turn requires that the process of diagnosis be recognized as medical.

Case 2: Jennifer

A crusty shell

One of Jennifer’s acupuncturists, Emma, once told me that diagnosis for her is not about

²⁹ Ibid, 6. emphasis mine

³⁰ Ibid, 19.

identifying a disease but rather recognizing and organizing patterns. When a patient who has “a lot going on” first walks in the door, their illness is tied like a knot.

Diagnosis means finding points of purchase and leverage from which to loosen the knot. When she told me this, I had been sitting next to her while she wrote up charts at her desk. A new patient came in and, as usual, she paused to listen and quickly peer through the small gaps in the bookshelf that stood between her desk and the waiting area. I looked around the corner of the shelf to see a woman in her mid-thirties in a tee-shirt and grey yoga pants.

Emma gestured me closer and said quietly, “she’s guarded. You can see she’s got a crusty shell. That’s from trauma. I can see it a mile away. I can usually tell what it’s from too.” Emma lifted her index finger to tick off the imaginary boxes of hypothetical patients, “you were in a war, abusive family, bad boyfriend, soul-crushing job, etc.” I look over again to get a sense of what Emma meant. The woman was alert but inattentive, like someone trying not to fall asleep while they are driving a car.

I was able to follow this patient during some of her appointment. She had come in seeking relief from arm pain that was the result of service in the military. She had a boyfriend who she described as “difficult to handle.” Among other things, he insisted that she stay on a restrictive diet so that she would lose weight. Once the patient was in the treatment room with “needles in,” Emma confided in me her desire to comfort this patient: “I just want to wrap her up in a blanket and feed her for two weeks.”

A few hours later, Jennifer arrived for an appointment. The day before had been her daughter Aisha’s first birthday. Jennifer somewhat sheepishly handed a large

drawing of Aisha to Emma.

“This is for you,” she offered.

“Thank you. It’s amazing,” Emma responded smiling broadly and making direct eye contact with the little girl in her mother’s arms. Later that evening, Emma hung the drawing in the clinic where it stayed for several weeks.

What that Situation was like

Jennifer never told me the name of Aisha’s father. I am relatively certain that he had a name and that she knew what it was but she never seemed to need it in our conversations. Usually, it was enough to just say “him.” One afternoon in the park she was explaining how he reported her to the city for benefit fraud while they were in the middle of their custody hearing. I asked incredulously, “who is this guy?” She looked me straight in the eye and said simply “my ex.” The tone of her voice and intensity in her eyes implied that she was doing me a favor by withholding his identity. I never felt the need to push her further on this point.

Jennifer gave very few details about what “her ex” was like or how he abused her even though she had almost certainly had to describe it in other settings. She had been deposed several times during the two-year custody battle initiated by her ex in what Jennifer believes was retaliation for the restraining order she had put on him. After winning custody, Jennifer also gave testimony in a local city council meeting

concerning the need to reform their system of restraining orders particularly for cases of domestic abuse.

Jennifer and her ex had had an “on-and-off” relationship for almost 10 years. Three years into it, she left him because he was “a horrible person.” They met again many years later. He told her he was sorry and had changed. They got back together but it wasn’t long before she had to leave again. Seven weeks after leaving him the second time, she found out that she was pregnant. Not wanting to raise the child on her own, she gave him another chance and moved back in with him. Speaking of her decision in hindsight, she said, “in your illogical overly hormonal state you justify forgiving someone and, like, allowing them the opportunity to quote-unquote step up.” But, he did not “step up.”

When I first asked Jennifer why she started doing acupuncture, Aisha was little more than 8 months old. We had met on the patio of a coffee shop near her house. The baby girl sat happily but noisily on her mother’s lap. She rattled her mother’s overburdened keychain, ran her tiny fingers across the latticed texture of the metal tabletop, and smiled at the variety of percussive effects she could produce. At the time, I was only vaguely aware that Jennifer had a history of trauma and abuse.

Victor: What is it that first made you aware of, or brought you to do acupuncture?

Jennifer: So, I had just come out of a really horrible relationship with Aisha’s father
it was really bad
and, it was abusive

on all different levels, financially, physically, mentally

I had left him and I basically, like, took my baby when he was out one day

he had needed to go somewhere and I

said 'oh yeah go'

and he was like out of town and I packed up all my stuff when he was gone

and I left

and it was really devastating because

you know

even though the relationship was over nobody plans to have a kid without a partner

I was living with an aunt before I came back with my family

and, my sister said to me, 'I'm going to acupuncture in LA and I found this card and

it has a leaf on it.' I was like,

'okay'

so, she took a picture of it and she texted it to me

so, I started going and I was a *hot mess*

I remember I had like a hole in my pants and I was just a mess

I could see, like, I was uncomfortable still because I was a new mom

it was really hard for me at first for me to get my mom or somebody to babysit

Victor: That's a lot to happen at once

Jennifer: It was a lot

Victor: I mean a lot

Jennifer: My story's like really crazy

this is like the tip of the iceberg

Just like being in that situation was like

[long pause]

and, I've told Emma this because I really feel like acupuncture helped me bounce
back

[crying]

I don't think like mentally I would have bounced back.

What exactly "that situation was like" always seemed to be suspended between ellipsis and lacuna. Jennifer did not describe her abuse or its repercussions outright. She never told me that he did this or that, or "there was this time when..." Her descriptions took the form of fragmented images: bruises, her daughter's broken toys, sleepless nights driven by thoughts of survival, being told to avoid going into the kitchen because there are knives there, watching people "beat the shit out of their kids" while standing in a welfare line. Her introduction to acupuncture is captured in an image as well: a leaf on a card.

After spending time with Jennifer in the clinic and meeting her several times to talk, I struggled to write and think about her case. Concern for diagnosis or what is sometimes referred to in the notes of a medical chart as her "chief complaint" had been the organizing principle behind the cases I had been trained to produce as an acupuncturist and in most of the illness narratives that I had read as an anthropologist. Terms like abuse and trauma, though they fit the circumstances, never felt adequate to

Jennifer's experience of illness and therapy. At times she hinted at the presence of a disease-like object, an object that she could feel but not identify.

One day, we were walking along the road near her mom's house trying to get her daughter to fall asleep. Aisha was 9 months old at the time and showed little interest in the nap that she surely needed. Sensing Jennifer's exhaustion, I asked to push the stroller for her. "Be my guest," she replied. The sound of cars on the busy street beside us meant there was no chance of others overhearing.

Jennifer: I feel like I have my secret,
it's like my secret illness
you can't really talk about it with people
it's like stigma that you have
about yourself
and I feel like acupuncture is one of those things that you don't have to
necessarily have
like, you can treat it without
without like a [partially inaudible]

The roar of a passing car drowned out the last word. In my notes written shortly after our meeting, I glossed what she said as: "Don't need diagnosis for acupuncture." I have an audio recording of the conversation, which I cleaned up as much as I could. For a long time, I transcribed the word as "level." When I realized that the word might be

important for this chapter, I emailed Jennifer and asked what she thought the word might be. She had no idea but guessed she was saying that acupuncture can treat you without “disclosing anything.” As it stands, I am confident that the word is “label” (i.e. “you can treat it without a label”). But it is fitting that I am ultimately unwilling to pretend that I have secured it. The struggle relaxed my hope of uncovering her secret label, of finding a key that could unlock the case. I became absorbed instead in the minutia, those small elements that seemed to anchor the twists and turns of her story.

Holes, knots, and other small signs

Jennifer had mentioned several times that there was a hole in her pants when she first started receiving acupuncture. The hole came up almost every time that we discussed her first experiences of treatment. She usually described it as a single hole but occasionally she implied that there was more than one. Jennifer gave very little indication as to why this hole was important. During the 10 or so months when she was going to acupuncture frequently, she spoke of the hole as if it was a symptom of her suffering.

Years after our first conversations and after she identified herself as having PTSD, Jennifer referred to the hole in her pants in a different way. In fact, she mentioned it just after her comments about being unable to form diagnostic words.

Jennifer: When you're seeking out help
you just know that you need help
you do your best logically to say, like, 'this is what happened to me'
but you cannot form the words like 'yeah, I think I have post-traumatic stress
disorder'
you don't even say it because you're in a state of shock or
a state of sadness or a state of like disbelief
you start hyper-focusing on like really stupid things like, I remember thinking
there was a hole in my pants
and how embarrassed I was that Emma would see this hole in my pants
looking back she probably didn't even give a shit
she was probably just like,
'whatever, there's people in here that don't wash their hair.'
your brain does these things where it tricks you to be like, 'well ok, focus on this
hole in your pants, not the fact that you can barely function or
you have no sense of personal safety'
you shut down different parts of yourself

The hole that was once an index of distress had become evidence of her inability to apprehend herself. This new perspective could be seen as reformulating the hole as the visible end of a defense mechanism (psychic investment in an object safely distant from the self) or fetish (the empowerment of an object by the mere belief in its power). But

again, these kinds of psychoanalytic notions weigh down rather than reveal possibilities of sense and reference. Hearing Jennifer bring up the hole again after so many years, I felt myself on the threshold of being absorbed into a secret language of pain, a region that Jennifer had fallen into but was unmarked on my map. It could only be uncovered by following the sound of her voice.

A second image that Jennifer invoked repeatedly during our conversations was what she called a “knot” or occasionally a “blood bubble.” For Jennifer, the knots were most easily expressed through a concrete experience that she had during one particular acupuncture treatment.

Jennifer: I remember, like, I had knots in my shoulders.

I remember the needle went in and I felt, like, this pop and I was like, ‘oh my god, I think that was, like, a blood vessel or something.’

So, I told Amy, [the acupuncturist],

and she was like, ‘no, it’s just it working something out.’

And, I think that was like my testimony to like,

‘okay, I actually feel something happening.’

At the time of our first interviews, Jennifer had been getting acupuncture twice a week for several months, a rate that she could afford because Emma’s practice model employed a sliding scale payment system whose prices went as low as \$15 per treatment. Jennifer tended to see acupuncture as working gradually, little by little, week

by week. The experience of the knot popping was decidedly different. It was a singular moment befitting a singular image of both her pain and its relief. It was a metonymic lightning strike that also foreshadowed a break in the storm. Jennifer called it part of her “road to recovery,” a path that was “so angry, so sad” and yet “manifest[ed] through acupuncture where it actually welled up into this little blood bubble.”

I was conducting fieldwork in the acupuncture clinic during many of Jennifer’s treatments though it is unlikely that I was there when she felt this pop. She was unable to specify the date of the treatment and I have no notes of her having an exchange with either Emma or Amy who were her acupuncturists at the time. When she first started acupuncture, Jennifer arranged for her mother to watch Aisha and was treated in the treatment room with the other patients. Jennifer’s mother was unable to watch Aisha often and Emma suggested that they treated her on the couch in the front room. Jennifer would try to sit Aisha on her lap. Amy and Emma would use acupoints on her ears and other strategic positions on her arms and legs so as to avoid them being grabbed by the infant. Aisha was often rambunctious and would climb onto the couch or crawl across the floor. Sometimes Shirley came out from behind the front desk to watch the child. Sometimes other patients would help out. I took turns too. I remember the exhausted yet intense look in Jennifer’s eyes as she sat on that couch with needles in her ears. She later told me that she valued the chance to watch other patients, especially the mothers. Motherhood had arrived unexpectedly and at a difficult time for her. Seeing other mothers going about their lives helped to ground her.

Because of where Jennifer received acupuncture I was able to observe her

treatments more closely than others. In the treatment room, conversations took place in hushed tones that were difficult to hear over the rushing sound of the white noise machines. The kinds of things that Jennifer would say to Amy or Emma seemed innocuous enough: "I'm doing pretty good," "I'm having a hard time this week," "the baby's been keeping me up and I'm really really tired," "my arm hurts; I think it's from, like, carrying her all the time." The quiet simplicity of these statements belied their intensity. She was quick to pull her hand into her sleeve and wipe the tears from her face so that others might not notice.

Even if I had overheard Jennifer call Amy over and express concern about a pop in her shoulder it is unlikely that I would have caught its significance. Years later as we sat together at a picnic table in the park, she still could recall the feeling.

Victor: Did you feel specific ways of getting better when you were getting treated or did it linger after?

Jennifer: No, it was definitely when I was getting treated when you're under a lot of stress, you don't recognize it as stress. you recognize it as your state of being. your whole body is just a giant knot and I remember I was actually in a room in the beginning and like she actually did something here [puts hand on shoulder] and I could feel it was like a pop.

I could feel the whole thing starting to untangle itself.

Jennifer's feeling of the knot was a very real and concrete embodied experience yet remained very strange and open to interpretation. She remembered her initial anxiety that the pop was an injury, the bursting of a blood vessel. Her acupuncturist, Amy, encouraged her to think of the pop as "just working something out" a turn of phrase that is ambiguous as to whether that "something" is a foreignness being expelled or an internal re-sorting.

The ambiguity of the knot and its popping sensation is not unique to Jennifer's case but resonates with what many patients have to say about their experiences of acupuncture. Mitra Emad, writing as both an anthropologist and from almost a decade of experience as an acupuncture patient, claims that when asked if acupuncture needles hurt the answer is both yes and no: "neither cultural error nor muddled ambiguity suffice to account for the translation and transformation of pain in the context of acupuncture care. What I've found is a cultural shift or movement from an experience of physical pain to one of sensation."³¹ Emad rejects the view that seeks only to eliminate pain and shows instead how pain can offer a potent "opening to bodily being."³²

The first time that I interviewed Jennifer she gave me the sense of these openings through what she called small signs.

³¹ Emad, Mitra. 2003. "Dreaming the dark side of the body: Pain as transformation in three ethnographic cases." *Anthropology of Consciousness*, 14 (2), 1-26. 13.

³² Ibid, 6.

Jennifer: I think what I like most about going [to Green Leaf] is how observant
they are to
how details
how the details matter
like, 'oh you look pale'
I kind of needed that extra care
I mean, how somebody is processing something
because anything that somebody emotionally feels it's physically manifested into
like these small signs
and, as a society, we're used to not paying attention to the small things
we're used to looking at a picture and how it should look
you know, I don't remember anybody ever really looking at me aside from my
mother and being like, 'you look a little pale today'

Taking Jennifer's knot to be just such a sign, I would argue that its sensations ground not only therapeutic transformation but the process of diagnosis as well. Jennifer told me that following the first year or so after leaving her ex, she realized that she had been relying on friends and family because she was unable to track her own emotional state. Friends told her that she had only recently begun to resemble the vibrant person that she once was. Her family noticed how over time she became more relaxed and less "sad all the time." The knot and the pain associated with it were powerful reminders that she could feel, which is in some sense to say that she was in touch with a body that could

feel. In this context, the arrival of a sensation, even one of pain, is complex. In her retelling of the experience, the knot seems almost a fulcrum from which to recognize and leverage the difference between the experience of her illness from that of herself.

The structure of a SOAP note

Jennifer's medical chart at Green Leaf was electronic. Technically, her chart was a combination of two different cloud computing programs: a scheduler that kept contact information (e.g. address, phone number, and emergency contacts) and a free electronic health records (EHR) program called "Practice Fusion." This divided method of charting came about because Emma and Amy did not trust Practice Fusion not to sell contact information out of their patient database but also did not like the interface that their scheduler offered to chart appointments.

When I requested Jennifer's chart, Amy printed the EHR for me. The print-outs were kept in a yellow folder locked in a cabinet behind the front desk. Each of Jennifer's appointments took up a single page of the printed record. The clinically relevant material was written as a "SOAP note," a standard form of documentation organized through the categories that make the acronym, Subjective, Objective, Assessment, and Plan. The 'subjective' and 'objective' sections are used to record findings about the patient visit as either they are reported by the patient (subjective) or as they are uncovered by examination, testing, or measurement (objective). The 'assessment'

category records possible diagnoses, etiologies, prognosis, and a variety of other evaluations of the patient and course of treatment. The 'plan' category records what the practitioner will do including treatments offered, referrals, recommendations, and the like.

Seth Holmes and Maya Ponte describe the SOAP note as a “ubiquitous and unquestioned [structure] in medicine” that has become so “deeply ingrained” that it is considered by many to be “indispensable[sic] to the efficient practice of contemporary biomedicine.”³³ Their ethnography of “problem-oriented patient presentations” in the context of clinical rotations in an American medical school describes the SOAP note as the primary means of achieving case legibility among medical professionals: “medical students regularly have the experience of presenting a patient’s illness in conversational format to the attending, who is unable to hear what they had clearly stated because it was not organized in the expected structure.”³⁴ Holmes and Ponte argue that the SOAP note blueprint tends to smooth over uncertainties in the clinical encounter in favor of a coherent linear plot in which each step further refines “complex, situated, individual human experience into decontextualized cases of universalized, standardized diseases.”

³⁵ In other words, emergent descriptions are rendered stereotypic.

Holmes and Ponte describe how narrative coherence in the SOAP notes is an effect of good medical writing that often requires that aspects of the clinical encounter are left out or reverse engineered in order to be legible. They give an example of being

³³ Holmes, Seth M., and Maya Ponte. 2011. “En-case-ing the patient: Disciplining uncertainty in medical student patient presentations.” *Culture, Medicine, and Psychiatry* 35 (2): 163–182. 166.

³⁴ Holmes and Ponte, “En-case-ing the patient,” 161.

³⁵ *Ibid*, 178.

chastised by an attending for writing about a patient's beliefs because not having a plan to address these beliefs "could leave the team open for litigation."³⁶ In another hypothetical example, they describe how a "student may have noticed in the patient's chart ahead of time the diagnosis of 'aortic stenosis' and thus chosen to describe the murmur as 'systolic, crescendo-decrescendo.'"³⁷ This kind of reverse engineering of diagnostic signs and symptoms works its way back to the chief complaint, which students learn to identify "not necessarily because it is most important to the patient and not entirely because it was the stated cause for the patient's visit, but rather because it begins the narrative by leading the listener in the direction of the diagnosis suspected by the medical student."³⁸

I bring up the work of Holmes and Ponte in detail here because the structure of Jennifer's SOAP notes is extraordinarily different. In the note for her first appointment, for example, the chief complaint is listed as "[back] pain and [wrist] pain,"³⁹ terms which then become sections in the subjective component of the notes. Under the heading of [back] pain, the acupuncturist, Amy, fleshes out this complaint saying that Jennifer "holds her tension in her [shoulders]; she feels like there are rocks there" and that she "ranks pain as 7 out of 10." Jennifer "attributes pain to stress" associated with an "abusive relationship." She "worries a lot about how her daughter deserves to be happy and she needs to be a better person for her" and that her family has been very

³⁶ Ibid, 174.

³⁷ Ibid, 175.

³⁸ Ibid, 171.

³⁹ My methodology for collecting data from patient charts includes substituting generic tags for any identifying information collected. Here, I have chosen to also replace certain diagnostic terms with like terms and have marked these replacement terms with brackets [].

supportive. Of wrist pain, Amy records that it “recently became swollen and painful” and that Jennifer does not know the cause. There are also two more headings detailing other unrelated aspects of Jennifer’s health history. The subjective component is less than 150 words but already paints a complex picture of how Jennifer’s pain is connected to different areas of her life. The narrative is replete with loose ends.

The objective component lists only two findings: “Pulse - thin and weak” and “Tongue - puffy, scallop, yellow coat.” There is a great deal that could be said about the place of pulse diagnosis in the way that Jennifer’s chart comes together. Here I want to note only two things. First, these kinds of pulse and tongue “images” are distinctive to East Asian medicine and therefore signal the potential use of its many categories of disorder and rubrics for assembling and interpreting clinical evidence. Second, these pulse and tongue images do not specify one diagnostic pattern of East Asian medicine but rather point towards particular classes of disorders. A “thin and weak” pulse image alone could apply to almost any set of symptoms or treatment protocols. The pulse and tongue images give a sense of Jennifer’s overall condition rather than identifying a specific pathophysiology.

The assessment reads: “Miriam Lee 10 – move qi and blood.” The “plan” lists acupoints used and a “treatment plan” recommending follow-up appointments “2 times a week for 6 weeks.” “Miriam Lee 10” is a curious phrase unique to certain circles of American acupuncture and used to indicate a formula of 5 bilaterally needled acupoints (listed in the plan as “LI4, 11, LU7, ST36, SP6”). Miriam Lee was a near-mythical figure in the modern history of American acupuncture. She popularized

these points in her clinical text *Insights of a Senior Acupuncturist* where she described them as “one combination of points [that] can treat many diseases.”⁴⁰ For many practitioners, especially those using community acupuncture style treatments, the point combination is a standard treatment protocol that can be used for any treatment used for the first appointment of any patient. Miriam Lee 10 is, therefore, less a diagnosis than a brief description of the treatment. The phrase “move qi and blood” is not much more of an assessment. It is rather a treatment strategy, and once again an extraordinarily generic one.

The SOAP note for Jennifer’s first treatment and its assessment, in particular, diverges radically from the problem-oriented approach of Holmes and Ponte’s interlocutors. In fact, to those familiar with its technical terms, the chart sounds more like the kind of narrative that medical students are being trained to avoid: a complex “jumble of issues with no clear entry-point for amelioration.”⁴¹ Back pain and wrist pain, abuse, worry about her daughter, the pulse image, and the point formula form a constellation of conditions that are never organized under the umbrella of a single diagnostic term (or collected under a series of separate terms). The distribution of meaning across these diagnostic signs contrasts starkly with the linearity and coherence of the problem-oriented approach.

In the notes for Jennifer’s follow up treatments, the diagnostic terms used shift significantly. Wrist pain ceases to become a chief complaint by the third treatment to be

⁴⁰ Lee, Miriam. 1992. *Insights of a senior acupuncturist: One combination of points can treat many diseases*. Blue Poppy Press.

⁴¹ Ibid, 177.

replaced by fatigue. In the fourth treatment, a “knot” is mentioned under the heading of back pain and is described as “about the size of a nickel on the right side next to the spine at approximately T7.” In the fifth treatment, the chief complaints are all still pain syndromes but in the subjective component there is the entry: “Emotions – feeling happy for the first time in a really long time.” In treatment six, three weeks after the initial visit, there is an entry in the subjective component that says, “mood is a lot better; didn’t realize her mood was so low until she started to feel good.” The assessments also vary. Until the eighth treatment, each assessment is used only once. Each SOAP note is its own snapshot, roughly framed and loosely organized into a portfolio without much of a master narrative beyond “acupuncture for Jennifer.”

Analysis of Jennifer’s case: Labels

Of all the things that acupuncture does not do, why is it important to Jennifer that it does not label her pathology? Jennifer’s lack of interest in receiving a diagnosis is quite similar to what has been described by Barbara Duden in her exploration of the bodily experiences of German women in Eisenach in the 18th century.

In a modern practice the aim of a doctor-patient interrelationship is predetermined, at least on the surface: the doctor is expected to make a diagnosis and cure the diagnosed illness. The women in Eisenach wanted neither of these

things. The circumstances leading to a complaint and the queries linked to them were as manifold and specific as the doctor's responses.⁴²

The need for a diagnosis is far from a timeless or universal feature of medical practice. Even in the history of what we might call Western medicine, the centrality of diagnosis is a relatively recent occurrence. The roots of such diagnostic power lay in the late eighteenth century and can be linked to the "medical gaze," an aspect of medical practice that Michel Foucault describes as an alliance between precise and stable uses of language and the value of spatialization and objectivity in medical perception.⁴³ Charles Rosenberg, citing the extraordinary expansion of diagnostic terminology both within medical circles and in public discussion, has argued that it is only within the last half-century that diagnosis takes center stage in biomedicine as "the presumed existence of ontologically real and definitionally specific disease entities constituted a key organizing principle around which particular clinical decisions could rationally be made."⁴⁴ Contemporary diagnosis, Rosenberg writes, "is central to the definition and management of the social phenomenon that we call disease... [it] labels, defines, and predicts and, in doing so, helps constitute and legitimate the reality that it discerns."⁴⁵

At first, Jennifer was unable to fully grasp her distress let alone assert its reality.

⁴² Duden, Barbara. 1998. *The woman beneath the skin: A doctor's patients in eighteenth-century Germany*. Harvard University Press. 91.

⁴³ Foucault, Michel. 1994. *The birth of the clinic: An archaeology of medical perception*. Translated by A. M. Sheridan. Routledge.

⁴⁴ Rosenberg, Charles E. 2002. "The tyranny of diagnosis: Specific entities and individual experience." *The Milbank Quarterly* 80 (2): 237–260. 239.

⁴⁵ Rosenberg, "The tyranny of diagnosis," 240.

All she knew was that something was wrong and that she needed help. Even if a term like PTSD was offered to her, she was not prepared to recognize the ways that it might apply to her life. A label might have been meaningless to her even if it was accurate.

How then did acupuncture work if not through labeling? It is worth noting that in Duden's opposition between contemporary diagnosis and clinical encounters in the German 18th century she uses a turn of phrase that is very similar to how Kotarba described acupuncture in the 1970s: instead of diagnosing a disease, the doctors *responded* to the *circumstances* of a patient. Furthermore, this difference between diagnosis as either labeling a disease or responding to a set of circumstances fits very well with the dichotomy between the stereotypic and emergent features of language noted by Agha. In so much of Jennifer's case, key moments of discovery and healing are emergent. What's more, they are formed not just in spoken or written language but through what Agha would call non-linguistic signs. Gestures, clothing, bodily dispositions, sensations, and feelings all lend form to her experience before it is brought into and reformed within language. The pattern of disorder that Jennifer eventually calls PTSD becomes available only after she is able to reflect on her state of being. Such reflections occur through her social relations, within her body, as well as in the context of acupuncture therapy.

One of the reasons that I present Jennifer's chart and illness narrative together as part of a collected case is to get around the division between patient experience and practitioner knowledge and show the emergent processes that lead diagnostic terms to be formulated across these different roles. Jennifer and her acupuncturists share a

“mutual orientation to a structure of information that unfolds while the sign-configuration is in play, not on conventions known in advance”⁴⁶ (to again cite Agha’s notion of emergent reading) even when they do not share the same details or interpretations of the circumstances of her life. The framework for communication and formulation of illness arises out of a therapeutic relationship built on the mutual orientation of patient and practitioner.

Thus, Jennifer is more than just a custodian of her illness experience. In the broadest sense, this idea fits with a foundational tenet of medical anthropology: that the models of illness and therapy used by patients are meaningful components of therapeutic practice not mere extensions or translations of models developed by medical institutions and deployed by healthcare providers. My approach, however, also departs from more typical rubrics for segregating the clinical encounter in terms of the “difference between the patient’s experience of illness and the doctor’s attention to disease.”⁴⁷ In much of medical anthropology, this dichotomy seeks to correct the privilege afforded to a medical system’s account of disease over that of the patient’s. Yet, it also circumscribes the patient’s role to that of feeling an illness. As Veena Das argues, patients often come to the clinical encounter already immersed in “social knowledge about disease, medical technologies, market strategies for sale of medicines, advertisements, and hundreds of other ways in which knowledge is secreted in the social world.”⁴⁸ Alice’s case can be read, for example, as an epistemological journey in

⁴⁶ Agha, *Language and social relations*, 258.

⁴⁷ Kleinman, Arthur. 1988. *The illness narratives: Suffering, healing, and the human condition*. Basic Books. xiii.

⁴⁸ Das, Veena. 2015. *Affliction: Health, disease, poverty*. Fordham University Press. 220.

which some aspect of illness or therapy comes to be known. In Jennifer's case, the path by which a disease comes to be known is perhaps less striking than that by which a diagnostic expression comes to be formed.

The various ways in which Jennifer's experience takes on both substance and form is worth exploring in the context of a much broader scholarly concern with the inexpressibility of pain, namely that an experience of suffering cannot be communicated to others even when it is undeniably apparent for the sufferer. Byron Good, for instance, claims that, because we "do not have direct access to the experience of others," analysis and interpretation must be used to chart a course between the pole of lived experience, which "always far exceeds its description or narrativization" and the cultural and narrative forms through which experience finds expression.⁴⁹ Perhaps a more classic example can be found in Elaine Scarry's claim that "for the person whose pain it is, it is 'effortlessly' grasped (that is, even with the most heroic effort it cannot *not* be grasped); while for the person outside the sufferer's body, what is 'effortless' is *not* grasping it."⁵⁰ Both Scarry and Good's work has been highly influential in the medical humanities and medical anthropology and has contributed to a common assumption that lived experience is synonymous with subjective experience, that illness experiences are formed entirely within the subject before forms of representation are sought to convey this experience to others.

But, is every experience of pain effortlessly grasped? Do I really have "direct

⁴⁹ Good, Byron J. 1993. "The narrative representation of illness." In *Medicine, Rationality and Experience: An Anthropological Perspective*, 135–65. Cambridge University Press. 139.

⁵⁰ Scarry, Elaine. 1985. *The body in pain: The making and unmaking of the world*. Oxford University Press. 4.

access” to my own experience of pain, suffering, or trauma? Jennifer struggles with the fact that her own suffering is often more available to others than it is to her. It is, in fact, partially an effect of therapy that she can recognize and handle her own experiences of pain. Phenomena like shock, numbness, anesthesia, and repression indicate that an important reason that patients may not be able to communicate pain is that they cannot grasp it in its entirety for themselves. Indeed, healthcare practitioners may be able to grasp its key components before the patient. The mutually orienting aspects of communicating through emergent language mean not only that practitioners can discern something within the patient but that patients are also prepared to receive an image of their illness back from the practitioner. Such preparation helps to ward off the danger of sudden revelation. The poet, Judith Harris, warns for instance that “to write or transmit a forgotten story, a writer must risk the unraveling of chaotic or suddenly grief-stricken emotions of which he or she may only now be conscious.”⁵¹ This threat of such a sudden unraveling seems to be tempered for Jennifer by an attention to what she calls small signs. These signs do not index a grand pathology, at least not at first, but provide points of purchase for loosening the knot bit by bit.

Conclusion: Emergence and stereotype

In presenting Alice and Jennifer’s cases here, I have tried to integrate two lines of

⁵¹ Harris, Judith. 2012. *Signifying pain: Constructing and healing the self through writing*. SUNY Press. 14.

inquiry into diagnosis in American acupuncture. One line sketches how diagnostic terms come to be formed in the life of a patient. The second follows diagnostic terms in order to paint a picture of the therapeutic activity to which they are tied and the ways in which that activity responds to the lives of patients. What draws these lines together is the concept of emergence and the possibility that diagnostic language can serve as a site of mutual reflection and correspondence.

I have turned repeatedly to Agha's notions of the emergent and stereotypical features of language not only because they are conceptually useful but because his larger framework for understanding social and cultural processes brings out the experience of patients like Jennifer and Alice. For Agha, language does not occupy a discrete world of discourse nor does it merely "stand apart from the 'thing' that it represents."⁵² It is rather an activity that participates in while also reflexively identifying and organizing other human activities. This approach sees "culture as a living process, as a thing whose arrangements are continually renewed – though not always at the same rate, or all at once – through the form-giving fire of human activities."⁵³

The living processes and form-giving fires that renew diagnostic terms are manifold. They can work at the level of social fact, in the epistemic and political projects of medical systems and institutions. But, they also include the more personal and circumstantial patterns that emerge out of the clinical encounters of specific patients and practitioners. What Agha's model of culture suggests is these different processes

⁵² Agha, *Language and social relations*, 1.

⁵³ *Ibid*, 2.

interact, interlock, and interfere with each other in complex and unpredictable ways. The common assumption with respect to biomedicine has been to see diagnoses as being formed by medical systems and institutions and then transported and applied at the level of the clinical encounter and the social world beyond medicine. This model is evident in Rosenberg who writes that “contemporary medicine and bureaucracy have constructed disease entities as socially real actors through laboratory tests, pathology-defining thresholds, statistically derived risk factors, and other artifacts of a seemingly value-free biomedical scientific enterprise.”⁵⁴ Once established, disease categories are deployed in the clinical encounter where they “provide both meaning and a tool for managing the elusive relationships that link the individual and the collective, for assimilating the incoherence and arbitrariness of human experience to the larger system of institutions, relationships, and meanings in which we all exist as social beings.”⁵⁵ While I find Rosenberg’s account to be quite insightful, my point is that diagnostic terms are not inert once they arrive in the hands of patients but must be renewed and/or reformed by them in order to be used. My intention is not to “level the playing field” so to speak, by putting patients and practitioners on equal footing but to explore the different kinds of footing with which each comes to claim diagnostic terms as their own.

Of course, one of the twists of acupuncture is its association with East Asian medicine and its approach to diagnostics. There are good reasons to both draw on and

⁵⁴ Rosenberg, “The tyranny of diagnosis,” 250.

⁵⁵ Ibid, 257.

reject the influence of East Asian medicine in this regard. One obvious problem is the fact that East Asian medicine covers an enormous body of material, social contexts, individual actors, and social organizations. East Asian medical diagnostics range from those found in the Taoist magical medicine of third-century China⁵⁶ to those used in Kampo prescriptions in Japan's National Health Insurance system in the twentieth century.⁵⁷ In many places and times, diagnosis in East Asian medicine resembled what it has come to mean for biomedicine today. As Hilary Smith states, "diagnosis—naming the thing afflicting a patient—may not have exercised the same degree of "tyranny" in premodern China as Charles Rosenberg suggests that it does in our time, but it mattered."⁵⁸ Judith Farquhar in her study of the "observation of illness" (*kanbing* 看病) under the Traditional Chinese Medical (TCM) model of the early 1980s described a logic of clinical encounter that turned on a form of diagnostic naming called syndrome differentiation (*bianzheng lunzhi* 辨证论治).⁵⁹

Yet, Farquhar also makes clear that syndrome differentiation is not the application of an abstract disease category but the expression of a pattern that incorporates the social, material, and personal contexts of the clinical encounter in Chinese medicine. Taewoo Kim, in his ethnography of Korean medicine, suggests a very similar approach to diagnostics, one that focuses "on the notion of 象(Xiang in Chinese and Sang in Korean pronunciation) as a vital means with which the interaction

⁵⁶ Strickmann, Michel, and Bernard Faure. 2002. *Chinese magical medicine*. Stanford University Press.

⁵⁷ Xu, Hao, and Ke-ji Chen. 2011. "Integrating traditional medicine with biomedicine towards a patient-centered healthcare system." *Chinese Journal of Integrative Medicine* 17 (2): 83–84.

⁵⁸ Smith, Hilary A. 2017. *Forgotten disease: Illnesses transformed in Chinese medicine*. Stanford University Press. 35.

⁵⁹ Farquhar, Judith. 1994. *Knowing practice: The clinical encounter of Chinese medicine*. Westview Press.

of language and the body is possible.”⁶⁰ Kim translates the term with the capitalized “Image” with which he means not a form of visual perception but a form or figure through which different bodily experiences can be found to resemble one another.

“Image” enables the practitioner to somatically conceptualize the core notions of East Asian medicine, such as Yin-yang and the Five Phases, and to use them as an embodied litmus as the practitioner’s cultivated body instinctively conjures up medical notions at clinical encounters.⁶¹

This focus on diagnostic Images helps practitioners to cultivate experience in the form of a “bodily appreciation of the medically meaningful.”⁶² It is within the perceptive reach of the body that this diagnostic process becomes coherently formed.

When we shift from an examination of Kim’s Korean medical practitioners to American acupuncture patients like Jennifer and Alice, “core notions of East Asian medicine” like Yin-yang and the five phases are lost while a “bodily appreciation of the medical meaningful” remains. Likewise, Sonya Pritzker has argued that, for American students of Chinese medicine, “felt experience, rooted in the body and emerging through interaction, is the existential ground upon which [Chinese medical] terms are understood by students and translated into practice.”⁶³ While this notion may make

⁶⁰ Kim, Taewoo. 2017. “Cultivating medical intentionality: The phenomenology of diagnostic virtuosity in East Asian medicine.” *Culture, Medicine, and Psychiatry*, 41 (1), 75-93. 85.

⁶¹ Kim, “Cultivation medical intentionality,” 78.

⁶² Ibid, 82.

⁶³ Pritzker, Sonya E. 2011. “The part of me that wants to grab: Embodied experience and living translation in US Chinese medical education.” *Ethos* 39 (3): 395-413. 399.

sense in the context of Chinese medical pedagogy and the importation of a foreign medical system, it seems far less relevant for the many acupuncture patients who seem to have little engagement with Chinese medical terms. It is not Chinese medical concepts that are being grounded in patient experience but biomedical terms like PTSD, cancer, and tendonitis that patients and practitioners are renewing and reformulating. The appeal to East Asian medicine seems to be less about the movement or translation of concepts than of a mode of practice responding to a novel set of circumstances.

Chapter 5

We have to ascertain how it works:

How acupuncture becomes Chinese medicine in the twentieth-century United States

On June 2, 1972, Saul Heller, the then president of the New York State Board of Medicine, proclaimed that acupuncture “to deaden the pain of surgery would be generally accepted in the country in two to five years.”¹ He made this prediction at a news conference held to announce a new theory of acupuncture developed by “two Chinese trained acupuncture researchers.”²

A brief article on the conference appeared on the front page of *The New York Times* the next day. The article said nothing of Chinese medicine or any other traditional ideas about acupuncture. Instead, it described the theory being put forward as indebted to Melzack and Wall’s gate control theory of pain. Readers were informed that “by applying needles to the face or ears, which feed directly into the thalamus, the ‘gate’ can be closed so that pain impulses from every part of the body will be blocked.”³ At the same time, the article included the doctors own concerns that their theory was not complete. There seemed to be widespread agreement that “some still more complex phenomenon must be at work.”⁴

¹ Rensberger, Boyce. June 3, 1972. “U.S. acupuncture use in 5 years is seen: General acupuncture practice in U.S. in 5 years is forecast.” *The New York Times*, 1972. 1.

² Rensberger, “U.S. acupuncture use in 5 years,” 1.

³ Ibid, 30.

⁴ Ibid, 30.

Compare this press conference and the reporting on it to a meeting of the United Nations Education, Scientific, and Cultural Organization (UNESCO) in Nairobi, Kenya in November of 2010. Almost 40 years after Heller's press conference a UNESCO committee at this meeting inscribed "acupuncture and moxibustion of traditional Chinese medicine" on their representative list of the intangible cultural heritage of humanity. In and of itself, the decision to recognize acu-moxa therapy as belonging to the cultural heritage of humanity may not seem that unusual. Yet when considered in the context of the other kinds of practices that have been registered and those whose nominations have been unsuccessful, the decision becomes less clear cut. Acu-moxa therapy is one of only a handful of medical or healing practices on a list dominated by traditions of performance, poetry, ritual, and craft. Acu-moxa is the first and thus far only aspect of Chinese medicine to be registered. Chinese herbal formulation and prescription, qigong, forms of therapeutic massage such as Tuina and Anmo, Chinese bone-setting, Chinese dietary therapy, fengshui, Chinese kungfu, and a host of other practices connected to Chinese medicine have been left unrecognized. The history of the nomination and deliberation process reveals that the privilege afforded to acu-moxa was not an accident. For instance, the Chinese government intentionally chose to nominate acu-moxa therapy instead of Taichi in 2010.⁵

Both the New York Board of Medicine news conference in 1972 and the UNESCO committee meeting in 2010 made efforts to raise the profile of acupuncture. Yet, they

⁵ Kan, Karoline. 2017. "Tai Chi encourages calm. So why are its Chinese fans stressing out?" *The New York Times* (Online); New York. March 17, 2017.

did so with completely opposing views on its cultural identity. In New York, the cultural aspects of acupuncture were denied in order to present the therapy as a medical procedure verified by scientific theory and experimental evidence. In Nairobi, the cultural roots of acupuncture are evaluated to, among other things, “contribute to raising awareness concerning traditional medicine worldwide.”⁶

Clashing and crossing

Why is the cultural identity of acupuncture ignored by some and upheld by others? The sociologist and medical ethicist, Paul Wolpe, has argued that representatives of biomedicine such as Saul Heller ignored the Chinese medical basis of acupuncture to maintain the authority of the medical profession.⁷ Acupuncture’s arrival in the United States in 1972 was “so sudden, and media attention so overwhelming, that the medical profession was caught off guard” and struggled to find ways to “assert, maintain, and interpret professional ownership of this emergent phenomenon.”⁸ Histories of acupuncture in the United States often support this view by presenting the globalization of acupuncture in the early 1970s as a moment of cultural clash:

⁶ United Nations Educational, Scientific and Cultural Organization, Intergovernmental Committee for the Safeguarding of the Intangible Cultural Heritage: Nomination files for inscription in 2010 on the Representative List of the Intangible Cultural Heritage of Humanity, ITH/10/5.COM/CONF.202/6 (6 October 2010), available from ich.unesco.org/en/6-representative-list-00335.

⁷ Wolpe, Paul Root. 1985. “The maintenance of professional authority: Acupuncture and the American physician.” *Social Problems* 32 (5): 409–424.

⁸ Wolpe, “The maintenance of professional authority,” 410.

Acupuncture, which has been used for 5,000 years as a part of traditional Chinese medicine, gained broad popular attention in the United States following the lifting of the Bamboo Curtain in 1971, which opened relations between the governments of the People's Republic of China (PRC) and the United States. Two significant factors contributed to this attention... The first was the treatment of *New York Times* columnist James Reston with acupuncture to alleviate the significant pain he experienced after undergoing an appendicitis operation while on tour in China. The second was the publication of glowing reports on the efficacy of acupuncture by a select group of American physicians who visited the PRC.⁹

This passage from the medical sociologist Hans Baer describes how a shift of political trade winds thrust acupuncture almost overnight before a Western audience. Several years of “acupuncture fever” followed in which the public and medical experts scrambled to come to terms with the practice treatment. Initial excitement and resistance from authorities within Western medicine subsided by the 80s making way for an ongoing process in which acupuncture struggles to claim its place in the American medical system. This history depicts acupuncture as a “Johnny-come-lately” new to the West while well established in the East. Very similar stories can be found on the websites of acupuncturists, in legislation and legal opinions, in the introductions to

⁹ Baer, Hans A. 2001. *Biomedicine and alternative healing systems in America: Issues of class, race, ethnicity, and gender*. University of Wisconsin Press. 94.

medical and scientific papers, newspaper and magazine articles, and in scholarship.

More careful historians reject the singularity of acupuncture's arrival in the 1970s as historically inaccurate and treat the forms of cultural difference that appear within this broader history in less absolute terms. The historian Roberta Bivins, for instance, has written accounts of acupuncture that begin as far back as the late seventeenth century with the Dutch physician Willam ten Rhijne's trip to Nagasaki (1674-1676) and his subsequent publication of a treatise on acupuncture.^{10,11} She portrays acupuncture as a phenomenon that ebbs and flows over a 400-year history between East and West with various points and moments of contact. The positions of the New York Board of Medicine and UNESCO might then fit into this more sustained historical account of interaction and competition between medical systems.

Since the 1970s, there has been an extraordinary rise in the availability and visibility of 'alternative', 'complementary', and 'cross-cultural' medicines. But is the astonishing popularity of heterodox medicine novel? Certainly, there have been other periods of tumultuous competition between medical systems, periods that powerfully shaped today's biomedicine. Bodily health and corporeal beauty have deep significance in historical, as well as contemporary, western cultures, and biomedicine has never been alone in seeking to provide them to an eager public.¹²

¹⁰ Bivins, Roberta. 2000. *Acupuncture, expertise and cross-cultural medicine*. Springer.

¹¹ Bivins, Roberta. 2010. *Alternative medicine?: A history*. Oxford University Press.

¹² Bivins, *Alternative medicine?*, 1.

Here cultures don't clash but *cross*. Medical systems come into contact, compete, blend into and affect one another all the while maintaining some degree of difference. To make this point more concrete, Bivins traces the global circulation of one particular discursive exchange about acupuncture in 1836, one which ultimately "illustrates the vital point that the cross-cultural transmission of medical knowledge and expertise—even 'alternative' medical knowledge and expertise—is not a uniquely contemporary phenomenon... [nor] was it ever a unidirectional process."¹³

The modes of historical analysis, exemplified by Baer and Bivins, coincide with different interests in understanding acupuncture in the present. The essentialist 'culture clash' version of history draws a clear line between Chinese medicine and biomedicine. It portrays two distinct sources of medical legitimacy and professional control each premised on what Wolpe calls the "consensually granted authority over a specific cultural tradition."¹⁴ The clash model is used by some to deride acupuncture as a superstition of the unenlightened past updated only to fit counter-culture sensibilities. Others use it to argue that these medical systems are different enough that distinct standards need to be developed and implemented for each. Either way, the cultural clash model maintains the ideal of a pure system of acupuncture that must have existed prior to the current period of intermingling. Frederick Kao and Ginger McRae, for instance, see in the rise of acupuncture in the United States a "lamentable...

¹³ Ibid, 2.

¹⁴ Wolpe, "The maintenance of professional authority," 409.

appropriation of acupuncture concepts and techniques.”¹⁵ The cross-cultural model, on the other hand, dispenses with notions of purity to focus instead on processes of translation, adaptation, reception, and interaction across difference. This mode of engagement has been customary for cultural anthropologists and ethnographers of Chinese medicine.

In the previous chapters of this dissertation, I have argued that to understand American acupuncture anthropologists need not assume that the practice is a culturally displaced modality of Chinese medicine. This critique allowed me to more fully explore the relation that American acupuncture has had to perceptual awareness, uncertainty, practical medicine, poetic configurations of space and material, and the emergence and expression of illness. In this chapter, I seek to tell a history of acupuncture that is neither of clashing or crossing but instead shows how the identification of acupuncture as a culture-based practice is itself contingent on historical and political circumstances. As I show in chapter 2, acupuncture was a frequent topic of discussion within the American medical community of the nineteenth century yet rarely considered with respect to East Asian conceptual frameworks or ways of life. Medical practitioners of the period thought of it instead as a surgical technique or a form of ‘practical medicine.’ The classification of acupuncture as a medical or surgical practice witnessed a steep decline in the twentieth century. One of the last remnants of its status as a medical technique is seen in Hill’s proposal for acupuncture to be used as “a new method of vaccination

¹⁵ Kao, Frederick F, and Ginger McRae. 1990. “Chinese medicine in America the rocky road to ecumenical medicine.” *Impact of Science on Society* 143: 263–73. 268.

which bids fair to do away with the old scarifying, scraping or scratching methods so familiar to our forefathers.”¹⁶ The increasing standardization and industrialization that came to dominate medicine in the early twentieth century weakened practical medicine as a viable basis for practice and with it the central grounds for accepting acupuncture. Meanwhile, acupuncture’s identification with Asian health practices and ‘superstitions’ was on the rise. The nadir of acupuncture practice in America lasted from the 1920s through the 1960s, especially at the height of anti-Asian racism during and after World War II.¹⁷

The lifting of the “Bamboo Curtain” in 1971 was indeed a decisive moment in the history of acupuncture albeit one of many possibilities. The biomedical community actively worked to articulate acupuncture within their ideological framework. Their efforts took the lead from medical institutions in China that had been experimenting with how to incorporate, integrate, and distinguish between what are now considered two different medical systems. Medical investigators who engaged in cultural exchange programs with their Chinese colleagues quickly became aware of the complex political stakes for acupuncture in China. For instance, attempts to ban Chinese medicine as a cultural relic in the Republican period¹⁸ had been reversed completely during the 50s and 60s to make Chinese medicine a “treasure house” of medical knowledge and

¹⁶ Hill, H. W. 1917. “Acupuncture: Best method of vaccination.” *The American Journal of Public Health* 7 (3): 301–2. 301.

¹⁷ The effects of racism during this period are described by William Bowen: Bowen, William M. 2002. “The five eras of Chinese medicine in California.” In *The Chinese in America: A History from Gold Mountain to the New Millennium*, edited by Susie Lan Cassel, 174–92. Alta Mira Press.

¹⁸ Lei, Sean Hsiang-lin. 2016. *Neither donkey nor horse: Medicine in the struggle over China’s modernity*. University of Chicago Press.

valuable site of cultural heritage.¹⁹ John Bonica, writing a much anticipated report in the *Journal of the American Medical Association (JAMA)*, depicted acupuncture in China as a practice in flux saying that, “in compliance with the aforementioned health policies and due in part to the influence of Western medicine, therapeutic acupuncture has undergone significant changes during the past several years, but especially since the Cultural Revolution.”²⁰ The Chinese themselves were still grappling with how acupuncture might be understood and used in the context of a modernized healthcare system at the same time that they were trying to present the Western powers with a coherent system of Chinese traditional medicine. Thus, I would argue that the reception of acupuncture in the United States was less a matter of cultural clashing or crossing than of the displacement of an already ongoing Chinese experiment in the co-construction of medical systems.

Surveys (n=220) conducted by Dorothy Rosenberg²¹ of participants in major acupuncture conferences in the United States during the crucial period of 1972-1974 show widespread agreement with the idea that “acupuncture is a set of procedures that can be incorporated into Western medicine without considering its origins in Chinese philosophy and medicine” (65% of participants agreeing and 21% disagreeing). Of the positions presented in the survey, this was the most popular followed closely by the idea of finding synthetic unity between the different medical systems (57% agreeing to

¹⁹ Taylor, Kim. 2004. *Chinese medicine in early communist China, 1945-1963: A medicine of revolution*. Routledge.

²⁰ Bonica, John J. 1974. “Therapeutic acupuncture in the People’s Republic of China: Implications for American medicine.” *JAMA* 228 (12): 1544–1551. 1545.

²¹ Rosenberg, Dorothy. 1977. “Acupuncture and U.S. medicine: A socio-historical study of the response to the availability of knowledge.” PhD Diss., University of Pittsburgh.

14% disagreeing). An even greater majority disagreed with the notion that “for acupuncture to work it may be necessary to accept a Chinese interpretation of man and his relation to the cosmos” (10% agreeing to 72% disagreeing). A variety of explanations were also on offer at the time ranging from the psychological to the biochemical, anatomical, and bioelectric. Practitioners and scholars often expressed strong opinions about what should happen with acupuncture precisely because its future was uncertain.

By the 1990s, opinions had solidified around a very different position. Acupuncture was by then considered first and foremost Asian (usually Chinese) in history and culture. The NIH’s 1997 consensus statement on appropriate and potential uses of acupuncture introduced the topic by saying:

Acupuncture is a component of the health care system of China that can be traced back for at least 2,500 years. The general theory of acupuncture is based on the premise that there are patterns of energy flow (Qi) through the body that are essential for health.²²

With its past and current theory belonging to China, the biomedical aspects of acupuncture could only be anticipated as a possible future. Thus, contemporary statements casually ignore almost 200 years of acupuncture’s history in American medicine (and much longer in Europe) while at the same time exaggerating the role played by acupuncture in Chinese healthcare during that same period.

²² “Acupuncture.” 1997. NIH Consensus Statement 15 (5): 1–34. 3.

Given the complex conditions that surround acupuncture's reemergence first in China in the late 1940s then in the United States in the 1970s, I would argue that by uncritically using culture as an analytic tool historians are putting the cart before the horse, which is to say, taking for granted a framework that is a contingency of the very history they seek to understand. This kind of critical approach to culture has further implications for how acupuncture can and should be approached ethnographically today. Since the 1970s, notions of cultural difference have dominated social scientific investigations of acupuncture. Following the lead of their interlocutors in the field, concepts like translation, acculturation, and cross-cultural interaction dominate ethnographies of acupuncture and Chinese medicine in a global context. Throughout this dissertation, I take care not to allow my ethnographic attention to become absorbed into questions of cultural difference and instead allow it to rest on questions of knowledge and awareness, pragmatics, emergence, selfhood, poetics, creativity, experience, place, and space. In this chapter, I turn my historical attention back onto cultural difference and how it is imagined and articulated with respect to acupuncture.

Certainly, scholarship examining the Chinese medical aspects of acupuncture has been insightful. I have been surprised however by the almost complete lack of a critical appraisal of this framework. Anthropologists have been seduced by the promise of acupuncture. As Peter Worsley notes in conjunction with Brian Inglis,²³ acupuncture in the 70s seemed to arrive like a sudden and "astounding revelation" that "finally

²³ Inglis, Brian. 1975. "Let me through, I'm a quack!" *Punch*, October 15, 1975.

exploded the myth of Western omniscience.”²⁴ It made an immediate case for an “anthropology of curing practices” that was more than just the study of primitive belief. Acupuncture provided the example of an effective and even superior traditional technique, a natural rebuttal to those who still felt that “few cultural relativists, suffering from a bad fever or a broken arm, would go so far to prove a point as to trade a modern physician for a traditional healer.”²⁵ Social scientific theories of expert knowledge and explanatory frameworks gained clinical relevance. Scholars like Nathan Sivin could make the case that, “if a qualified traditional physician, or someone who thoroughly understood Chinese therapeutic reasoning [had been involved in acupuncture research]... the research sponsored would have been more realistic in its claims, more deliberately paced, more critically evaluated, and more productive.”²⁶ Acupuncture could sit at the head of a phalanx of integrated medicine which, when combined with the notion of cultural competence training for physicians, thoroughly justified investment by American medical institutions in the burgeoning field of medical anthropology. At the same time, acupuncture’s revolutionary and anti-western heritage made it equally amenable to more critical versions of medical anthropology emerging out of feminist and post-colonial approaches. Acupuncture supports each of these positions because it is deemed both medically effective and culturally inflected.

The full story of how acupuncture and medical anthropology helped to legitimize each other is long and twisting. This chapter is less a map that charts the road

²⁴ Worsley, Peter. 1982. “Non-western medical systems.” *Annual Review of Anthropology* 11 (1): 315–348. 316.

²⁵ Starr, Paul. 1982. *The social transformation of American medicine*. Basic Books. 4.

²⁶ Sivin, Nathan. 1986. “Traditional Chinese medicine and the United States: Past, present, and future.” *Bulletin of the American Academy of Arts and Sciences* 39 (8): 15–26. 22.

in its entirety than an attempt to point out some of the bumps and blind corners, the forks and crossroads, the paths not taken and those that have fallen into disrepair. I will begin early in the twentieth century.

The nadir (1910-1970)

Acupuncture use in the United States reached its lowest point in the early to mid-twentieth century. Very few practitioners or researchers took up the therapy and historians and medical writers presented acupuncture as a practice whose time had passed.

In part, this was due to the rise in institutional regulation and state sponsorship of medicine. The Flexner report of 1910 is perhaps the most obvious landmark for the extraordinary stock medicine then placed on science and standardization. Acupuncture, though it had been used by a variety of practitioners throughout the nineteenth century, had no patron (or class of patrons) to usher it into the new hegemony. Itinerant practice, practical medicine, and the theory of counter-irritation each once a vital part of American medicine had become marginalized. Acupuncture could not turn to Chinese medicine in the United States for support either. Chinese doctors in the United States faced significant social and political pressure during this period. On the occasions when these doctors did produce public or legal arguments in favor of Chinese medicine, they were concerned with herbal practice not acupuncture.

As acupuncture ceased to become a live question for medical practice, it was entrusted to academics, who foregrounded its association with East Asia. By and large, the medical establishment forgot the boom years of the 1820s and the continued usage of acupuncture into the late nineteenth century. Those that did remember generally reframed acupuncture use in the United States and Europe as part of its historical movement out of China. For instance, at the commencement address given to Jefferson Medical College in 1923, Edward Hume placed acupuncture among the Chinese contributions to medicine.

Acupuncture is [in addition to moxibustion] a second established Chinese procedure. 367 points are described on the surface of the body, at which the insertion of a needle is supposed to afford outlet for harmful spirit influences. But while the dangers of infection and trauma are real, the physical benefits of its wise use are admitted. Acupuncture was carried to Japan, and thence to Europe by Ten-Rhyne, a Dutch surgeon, at the end of the seventeenth century. In France it had quite a vogue a century ago. British teachers, such as Sir James Cantlie, have tried it on sprains and chronic rheumatism and report successful cases.²⁷

For Hume and other writers of the early and mid-twentieth century, acupuncture was a

²⁷ Hume, Edward H. 1924. "The contributions of China to the science and art of medicine." *Science* 59 (1529): 345–50. 349.

cultural practice supported by particular concepts and beliefs. Here it is a “Chinese procedure” meant to deal with “harmful spirit influences.” Their investigation of acupuncture begins with ideas like the networks of acupoints and movement of vital spirits, ideas that became increasingly distant and historicized over time. By the mid-century, authors like J. I. Wand-Tetley referred to acupuncture in the past tense and associated it with the “frozen, megatherial system” of Imperial China.²⁸ While he recounts a history of acupuncture practice in the United States and Europe he marks its downfall with the end of humoral medicine and the publication of texts like Rudolf Virchow's *Cellular Pathology* in 1858.

The notion of acupuncture as an empiric, emphasized so eloquently by Oliver Wendell Holmes Sr.²⁹ little more than 50 years earlier, was no longer in favor. Like Holmes, medical writers of earlier periods tended to portray Asian acupuncture as a practical discovery albeit one that suffered under the Asian inclination to adhere to strict sets of rules. The incorporation of acupuncture into a medical future was fairly straightforward then: reduce Asian rules of practice to a collection of empirical findings and start experimenting. In the twentieth century when acupuncture was no longer a “living” biomedical practice, doctrinal difference became much more important. Furthermore, anything considered a medical innovation had to be adequate to regulatory, educational, and research regimes to be fully incorporated into biomedicine.

While attitudes towards acupuncture were solidifying in the United States they

²⁸ Wand-Tetley, J. I. 1956. “Historical methods of counter-irritation.” *Rheumatology III* (3): 90–98. 94.

²⁹ Holmes, Oliver Wendell. 1891. *Medical essays, 1842-1882*. Houghton, Mifflin and Company.

were undergoing profound transformations in China. Unlike the history of acupuncture in the United States, the history of Chinese medicine during this period has been depicted through a number of historical accounts, most notably by Kim Taylor,³⁰ Sean Lei,³¹ Bridie Andrews,³² Volker Scheid,³³ and Andrews and Mary Brown Bullock.³⁴ The changes began in the Republican government of the late 20s when medical reformers trained in biomedical practices (by way of Germany and Japan) sought to abolish Chinese medicine.³⁵ In response, an alliance of Chinese medicine practitioners and Chinese pharmaceuticals sellers mobilized to achieve recognition and legitimacy before the state. This struggle led to a Republican period that featured “two parallel institutions, one Western and one Chinese, each politically and educationally distinctive.”³⁶ Proponents of Chinese medicine positioned themselves as anti-imperialists while biomedical advocates as modernizers. Under the Communists, the role of the state changed drastically. Whereas it was once an arbiter of claims and a stage for performances of legitimacy, Mao and party leaders pushed Chinese and Western medicine to serve the projects of the state. These projects fell under a variety of banners such as cooperation (hezuo 合作) between medicines from 1945-1949 and the unification (tuanjie 团结) of medicines from 1949-1953.³⁷ In the 50s and 60s, distinct

³⁰ Taylor, *Chinese medicine in early communist China*.

³¹ Lei, *Neither donkey nor horse*.

³² Andrews, Bridie. 2014. *The making of modern Chinese medicine, 1850-1960*. UBC Press.

³³ Scheid, Volker. 2002. *Chinese medicine in contemporary China: Plurality and synthesis*. Duke University Press.

³⁴ Andrews, Bridie, and Mary Brown Bullock. 2014. *Medical transitions in twentieth-century China*. Indiana University Press.

³⁵ Lei, *Neither donkey nor horse*.

³⁶ Elman, Benjamin A. 2009. *A cultural history of modern science in China*. Harvard University Press. 210.

³⁷ Taylor, *Chinese medicine in early communist China*.

institutions of Chinese medicine were established and the medicine became standardized.

Chinese medicine during this period rode out waves of extraordinary social and political upheaval and often reformulated itself even during times of relative stability. It endured both radical reforms and moments of sudden and intense investment to emerge not simply as a continuation or return to traditional practice but as a complex system of healthcare compatible with competing and often radically different aspirations towards modernity. The movement towards modernization almost always meant the accommodation of some image of science in either its Japanese, Soviet, Chinese, or American flavors. Massive reforms to theory and practice occurred during this period. Entirely new social and political support structures were developed. Chinese medicine found in China during this time could not be more removed from the notion of a “frozen, megatherial system.”

As big as the changes were for Chinese medicine, they were even greater for acupuncture. Not only was acupuncture being radically reinterpreted by physicians and writers like Cheng Danan who following the lead of the Japanese sought to reframe acupuncture in terms of Western anatomies of the neurological system^{38,39} or Zhu Lian whose “new acupuncture” completely redrew the meridians of the body in terms of a political and military idiom better suited to science under communist governance.⁴⁰ These reformers advocated for change at almost every level of practice from the types of

³⁸ Elman, *A cultural history of modern science in China*.

³⁹ Andrews, *The making of modern Chinese medicine*.

⁴⁰ Taylor, *Chinese medicine in early communist China*.

needles used, to how they were sterilized, to the locations and techniques of insertion.

The increased status afforded to acupuncture as a modality of Chinese medicine also had an impact. Acu-moxa therapy (zhenjiu 針灸), had long been considered a fairly insignificant backwater of the Chinese medical landscape. The communist party “was the first ruling government in China to recognize officially the medical discipline of acupuncture in over a century.”⁴¹ Yet even for the communists, the enthusiasm for acupuncture was not sustained. Its advocates, like Zhu Lian, were at their strongest during the upheaval of the civil war, especially in the rural areas. Support for acupuncture waned with the establishment of a national healthcare system and once the urban hospital came to dominate its institutions. Ethnographies of Chinese medicine in China based on fieldwork conducted after the 1980s all subordinate acupuncture to the practice of herbs.^{42,43,44,45}

The remarkable rise of acupuncture in the late 40s and early 50s occurred in a very unstable social context. During first the war with Japan then the civil war, in a land in which political and social life was in disarray, medical institutions could not maintain ideological standards for practice. In fact, one of the advantages of acupuncture was how little “culture” was necessary to use it. Even people of a “low cultural level” could learn it.

⁴¹ Ibid, 29.

⁴² Farquhar, Judith. 1994. *Knowing practice: The clinical encounter of Chinese medicine*. Routledge.

⁴³ Scheid, *Chinese medicine in contemporary China*.

⁴⁴ Hsu, Elisabeth. 1999. *The transmission of Chinese medicine*. Cambridge University Press.

⁴⁵ Zhan, Mei. 2009. *Other-worldly: Making Chinese medicine through transnational frames*. Duke University Press.

Zhu Lian felt that acupuncture had the right qualities to serve the needs of the Communist Party in wartime China. She emphasized just how self-sufficient the system of acupuncture could be. All you needed were needles, alcoholic spirits, cotton-wool, moxa and an explanatory handbook! Acupuncture was cheap, effective, very portable and, if the instructions in her book were followed carefully, it was a very safe form of treatment as well... Zhu Lian pointed out that 'the sanitation and medical problems of China's population of six hundred million are not going to be solved by a handful of Western medical doctors' and she thus proposed that a large number of middle-level public health workers should be trained. She thought that acupuncture could be learned quickly by 'people of a low cultural level'... This medicine was therefore meant to be used by the masses to serve the masses.⁴⁶

This medicine by the masses and for the masses would be redeveloped later as the "barefoot doctor" program of the Cultural Revolution, a program whose practitioners were purported to work with "a needle and a handful of herbs." The same traits that excited the itinerant American practitioners of the 1820s were touted for the Chinese during this time: acupuncture is safe, easy to learn and use, and effective. In addition, acupuncture fit well with the military-political ideologies of the early Chinese communists. As Paul Unschuld writes, Mao sought a revolutionary "new medicine" that followed the model of dialectical materialism such that therapy entailed the

⁴⁶ Taylor, *Chinese medicine in early communist China*, 24

“application of a purely external stimulus for transformations that were to occur within the organism.”⁴⁷ Acupuncture seemed the perfect technique to realize this model of therapeutic transformation.

The global stage had been set. In the United States, acupuncture had been increasingly seen as an archaic practice associated with China. In China, the place of acupuncture was changing drastically as the emerging state began to bring medicine into its revolutionary national project. When these two very different trajectories of acupuncture would come together in the early 1970s they might as well have been meeting for the first time.

Acupuncture fever (1971-1979)

There has perhaps never been a time when global interest in acupuncture was as intense as the early 1970s. Between 1972-1974, acupuncture conferences, committees, articles, reports, journals, and organizations sprang up so quickly that it is still difficult to keep track of them all. John Bonica, a physician not prone to hyperbole, wrote in the forward to one such report, “nothing in recent years has aroused so much curiosity or generated as much interest as has acupuncture.”⁴⁸ The sudden attention was made possible by the establishment of diplomatic relations between the United States and

⁴⁷ Unschuld, Paul U. 2010. *Medicine in China: A history of ideas*. University of California Press. 255.

⁴⁸ Bonica, John J. “Foreword to monograph for Fogarty International Center - approved November 4, 1974.” Box 59, Folder 15. UCLA Special Collections: Bonica Papers.

China in the wake of Nixon's visit in 1972. However, the social dynamics of acupuncture's rise do not proceed in a teleological or stepwise fashion as many common histories portray. Acupuncture was taken up in very different ways and moved through very different trajectories with respect to medical institutions, the popular imagination, and social and political movements.

At the time, it was unclear as to how these wide-ranging approaches could be merged or if they were even compatible at all. American medical institutions largely tried to frame acupuncture as an innovation to be tested. In opposition, patient groups advocated for greater access to the therapy. Counter-culturalists argued that acupuncture validated the effectiveness of alternative ways of perceiving the world. Social justice movements like those of the new left drew on acupuncture's revolutionary and itinerant roots and promoted the therapy as a low-cost solution to public health challenges faced by vulnerable populations (particularly with respect to drug addiction). Faced with the outpouring of interest coming from the United States and Europe, even Chinese medical institutions reexamined their use of acupuncture and renewed their claim to it. In this section, I will provide a sense of how these distinct trajectories bent towards a notion of culture in which acupuncture would ultimately find common expression.

American medical institutions initially thought of acupuncture as a medical innovation. In her dissertation completed in 1977, Rosenberg provides one of the clearest accounts of this way of engaging with acupuncture both in the evidence she

gathers as well as the assumptions embedded in her analytic framework.⁴⁹ She portrays medical institutions as patient, confident, and even aspirational about their ability to evaluate and bring acupuncture into the fold. Medical practitioners expected to be able to evaluate acupuncture's effectiveness, uncover its physiological or psychological basis (if any), and properly regulate its use. Rosenberg also shows how acupuncture's reception was far from monolithic among the medical community. Institutional and professional organizations sought to keep acupuncture in the hands of researchers and out of clinical practice by insisting that it was "experimental." She argues that professional organizations like the American Medical Association (AMA) and the American Society of Anesthesiologists (ASA) were caught up in their concern for the medico-legal issues raised by acupuncture use and their need to maintain authority over all medical procedures. Wary of the way that the politics of the Chinese cultural revolution continued to color the practice, these organizations did not want to import the PRC model of acupuncture. Without a clear mechanism or sense of the risks and benefits, they were unsure as to how acupuncture should be classified, who could use it, when, for what types of disorders, and with what risks. Yet given the invasive and therapeutic nature of the procedure, they also hoped to avoid ceding their authority to non-biomedical practitioners. Physicians eager to make acupuncture available in their clinical practices, on the other hand, "expressed strong opposition to their profession's official position that acupuncture was an experimental procedure."⁵⁰

⁴⁹ Rosenberg, "Acupuncture and U.S. medicine."

⁵⁰ Ibid, 294.

One often-overlooked cause of confusion for the medical community was that what they were calling acupuncture was an amalgamation of several different types of practice. Acupuncture in China at that time included what looked to Western eyes like three relatively distinct contexts of use: acupuncture anesthesia, therapeutic acupuncture for pain, and the general practice of acupuncture. It was easy to imagine acupuncture anesthesia taking the place of the standard anesthetic techniques of the time. Even if its theoretical basis was unclear, the way acupuncture anesthesia could be used, who would use it, how it would be evaluated and reimbursed was a straightforward extension of the existing system of medical specialties. Acupuncture as a therapy for pain was more difficult to place. To many, it made sense as a specialty practice working within the emerging interdisciplinary field of pain management or more broadly integrated into the clinical logics of a specialty like anesthesia, nursing, or primary care. The general practice of acupuncture used for a wide variety of symptoms, illnesses, and disorders, and its complex practical and theoretical logics was a far greater challenge for uptake into biomedical practice. General acupuncture would be difficult to incorporate as anything less than an entirely new modality of treatment. Of the different forms of acupuncture, the promise of general practice acupuncture received the most intense skepticism and the least research attention. It was often derided as quackery and associated with the cure-all herbal tonics of earlier centuries. The hierarchy of medical interest in acupuncture thus heavily favored its use in anesthesia.

To many in the medical profession, the alternative conceptual framework

provided by Chinese medicine seemed an unnecessary complication of the planned research program to evaluate acupuncture. Here, for example, is the transcript of a discussion about the physiology of acupuncture points used for surgical anesthesia at the National Institutes of Health (NIH) Acupuncture Research Conference of 1973:

Dr. Shnider: Well, the reason I asked [how points were chosen] is that classical texts discuss the balancing of Yin and Yang by means of appropriate meridians. They do not mention surgical analgesia.

Dr. Katz: Frankly, I believe that is merely an exotic, philosophical explanation used to tie a number of practical observations together. There are many parallel examples in history, where explanations bear no real relation to the events they are supposed to account for.

Dr. Frederick Kao: The classical points were worked out about the second or third century, A.D., and those people never mentioned five elements or Yin-Yang. That goes further back, about 3,000 years ago. Let's not confuse everybody today by referring to what the Chinese believed 3,000 years ago. Currently in China, for example, they have no trouble in using x-rays and acupuncture side by side. The five elements are not brought in, and Yin-Yang is treated as a useful concept, like wet and dry, or hot and cold.

Dr. John Bonica: As a physiologist what do you think about it?

Dr. Kao: Just as a broad, superficial generalization—even computers operate on the Yin-Yang principle. But this is not our purpose here, leave it to

historians. It has no specific relation to physiological activities.⁵¹

Well-versed in the many a diverse approaches taken to acupuncture throughout Chinese history and in what was then contemporary China, Kao saw yin and yang as useful but not necessary concepts.

John Bonica investigates

Acupuncture generated tremendous excitement and curiosity among many westerners in the American medical community who were committed to biomedical models. Not least of which was the prominent anesthesiologist and father of the field of pain management, John Bonica. Bonica is a useful figure to examine in the context of the diverse and often conflicting interests that various medical, political, and popular organizations had in acupuncture during this period. Because he was respected as a researcher, clinician, as well as an advocate for patients and because he was so engaged with medical institutions around the world, he was seen as an ally by many of the acupuncture organizations that sprung up during this period both within the United States and internationally. Bonica also presents a useful window onto this period because of the breadth and depth of the archive of his papers available, which include

⁵¹ Jenerick, Howard P., ed. 1974. *Proceedings / NIH acupuncture research conference, Feb. 28 and Mar. 1, 1973, Bethesda, Md.* DHEW Publication ; No. (NIH) 74-165. U.S. Dept. of Health, Education, and Welfare, Public Health Service, National Institutes of Health, National Institute of General Medical Sciences. <https://catalog.hathitrust.org/Record/000026613>. 110.

journals, personal calendars, correspondence, travel logs, clippings and collected academic articles, invitations to conferences, and a variety of other ephemera.⁵²

Among researchers and clinicians, Bonica was known as being practically minded, scientifically deliberative, as well as a powerful advocate for medical institutions.⁵³ Based on his reputation and history of accomplishment, Bonica was entrusted by several medical and research organizations to evaluate the viability of acupuncture for American medicine. He was quickly recruited to serve on the ad hoc acupuncture committees assembled by the American Society of Anesthesiologists (ASA), the American Medical Association (AMA), and National Institutes of Health (NIH). He was invited to participate in most of the major acupuncture conferences of the day (of which there were dozens) and between 1972 and 1975 participated in at least 10 separate national meetings and conferences on acupuncture. He led a live televised panel discussion on acupuncture that aired nationwide and was interviewed by an array of other news and media figures. In the summer of 1973, he spent three weeks with a medical delegation to China investigating aspects of their medical system and acupuncture anesthesia in particular. In 1974, he published two white papers, one on acupuncture anesthesia⁵⁴ and another on acupuncture therapy⁵⁵ describing his findings concerning acupuncture in China.

⁵² I spent several weeks examining the Bonica papers in the UCLA library's special collections.

⁵³ Bonica served as the president of the American Society of Anesthesiologists (ASA) and of the World Federation of Societies of Anaesthesiologists (WFSA), founded the International Association of the Study of Pain (IASP) and a multidisciplinary pain clinic at his home institution of the University of Washington Medical Center.

⁵⁴ Bonica, John J. 1974. "Acupuncture anesthesia in the People's Republic of China: Implications for American medicine." *JAMA* 229 (10): 1317–1325.

⁵⁵ Bonica, "Therapeutic acupuncture in the People's Republic of China."

When Bonica traveled to China as part of a series of “scientific exchanges,” he saw a host of factors that made him question whether or not acupuncture would be useful in the United States. Lack of clinical research was one important issue. While he acknowledged the extent of Chinese research on acupuncture mechanisms, he was surprised at how few clinical research trials had been done on this topic. He was also distrustful and suspicious of the way acupuncture was being presented by the Chinese government. Chinese sources gave conflicting estimates of acupuncture usage most of which seemed grossly exaggerated.⁵⁶ “If acupuncture [anesthesia] is in fact simple and effective,” he wrote, “why is it not being used in commune and factory hospitals that lack complicated anesthetic machines and trained anesthetic personnel?”⁵⁷

It also was strikingly obvious to Bonica that acupuncture was being presented to visiting scientist as part of a political project on the part of the PRC. Information pamphlets being distributed to American physicians by the PRC often began by praising “our great leader Chairman Mao” and the effort by researchers to “[combine] revolutionary zeal with a scientific approach” that led to the development of techniques such as acupuncture anesthesia.⁵⁸ The first instance of acupuncture anesthesia presented to Bonica during his trip to China was during a lobectomy. Bonica reported:

⁵⁶ “Reports by most previous visitors to China have given the American public and medical profession the impression that acupuncture anesthesia is being used widely for many, if not most, operations and is highly effective in most patients. However, I found this not to be the case... I doubt that currently acupuncture anesthesia is being used in more than 10% of the surgical operations done throughout China.” Bonica, “Acupuncture anesthesia,” 1318.

⁵⁷ Ibid, 1324.

⁵⁸ *Acupuncture Anesthesia*. 1972. Peking: Foreign Language Press, box 66, folder 1, UCLA Special Collections: Bonica Papers. 1

Immediately upon the incision he showed manifestations of discomfort, he showed tenseness in his face and the blood pressure went up to 140/80, and pulse rate increased from about 60 to about 90... They had indicated that they had prepared the patient by teaching him how to breathe and they asked the patient to breathe according to the preparation, but it was obvious that the patient had a surgical pneumothorax[sic]... He complained of the fact that he had difficulty in breathing and they gave him oxygen by mask in a closed system at 1 liter per minute. The pulse rate rose to about 100 at this point and things went off. It was obvious that the patient was shunting although he was [in] remarkably good condition considering the tremendous amount of collapse of the procedure... The patient undergoing lobectomy did make a comment that [he] was pleased to have the opportunity to participate in this kind of anesthesia which was only due to the progress promoted by Chairman Mao.⁵⁹

The enormous political investment by the PRC led many to write off acupuncture as political theatre. Bonica did not. He speculated that the effects of acupuncture anesthesia were operating within a complex of objective and subjective components which he referred to as a "combination of peripherally induced neural synaptic inhibition and psychophysiologic mechanisms,"⁶⁰ which included the social and

⁵⁹ Bonica, John.. "Trip to the People's Republic of China." Box 66, Folder 52. UCLA Special Collections: Bonica Papers. 12-13.

⁶⁰ Bonica, "Acupuncture anesthesia," 1324.

political conditions under which the procedure occurred. The specificity of the Chinese context made it difficult to predict how acupuncture would work elsewhere. Speaking to a radio reporter several months after returning from China, Bonica expressed his “own personal view” that although he “believe[s] the reports that are coming out of China that it does work there” he suggested that “what we have to ascertain is how it works, and what conditions contribute to the success, and whether these same conditions are available here in the United States.”⁶¹

Bonica’s notion that subjective conditions can have profound effects on the perception of pain must be placed in the context of what Keith Wailoo⁶² has identified as a “liberalizing” tendency of pain therapies that arose within the United States in the 1960s.⁶³ Bonica and other leaders of the pain field were keen on understanding the subjective elements of pain and considered “radical and so-called ‘alternative’ remedies—opening their minds to hypnosis, mind cures, and placebos.”⁶⁴

Speaking in a 1970 CBS television broadcast, “The Mystery of Pain,” [Bonica] admitted that “the response of the individual [to pain] depends on a great variety of factors.” Pain response was “influenced by age, by sex, by culture,

⁶¹ Lawrence Dulcie. October 6, 1972. “Dr. John Bonica discusses use of acupuncture.” <https://archive.mpr.org/stories/1972/10/06/dr-john-bonica-discusses-use-acupuncture>.

⁶² Wailoo, Keith. 2014. *Pain: A political history*. JHU Press.

⁶³ Wailoo uses the terms liberal and conservative in accordance with American politics, particularly of the late twentieth century. Liberal approaches to pain emphasize the subjective experience of pain and their root in the social and environmental contexts while conservative approaches portray pain as objective with its roots in the individual body. A politics of pain results when American liberals seek to redress pain through social and governmental programs while conservatives deploying skepticism to criticize these approaches as fostering only deceitful claims.

⁶⁴ Wailoo, *Pain*, 200.

by ethnic background. It is also greatly influenced by what the pain means to the individual—is it a bad omen, or is it something not so bad.” Pain, he noted, was so intimately tied to culture and personality that no scientist could speak on pain better than those who experienced it.⁶⁵

Culture was an important factor in Bonica’s evaluation of acupuncture. His notion of culture included the beliefs and meanings that patients attached to illnesses and medical interventions. For Bonica, the operation of the acupuncture needle in Chinese surgical theaters could not be disentangled from either the figure of Chairman Mao, the progress of the nation, nor the conditions of intense scarcity of medical material and personnel. Likewise, the preparation of the patient through breathing exercises and counseling sessions could be seen as contributing to “psychophysiologic mechanisms” or a “hypnotic element” that would be difficult or even impossible to recreate in the American context. Deploying notions of culture and condition, Bonica was able to agree that acupuncture was effective in China, while still expressing skepticism towards its applicability in the United States.⁶⁶ None of this suggested the need to excavate traditional concepts or explanatory frameworks of acupuncture. Bonica concluded that experimental evidence, especially in the form of clinical trials, was needed before

⁶⁵ Ibid, 213.

⁶⁶ “The Chinese are more successful with the procedure than are others for a variety of reasons, including intense preoperative counseling and preparation, their admirable ability to tolerate moderate to severe pain, the intense motivation provoked in the patient and surgical team by the necessity created by shortage of anesthetic personnel and by political and ideologic factors, and the skill, gentleness, and dexterity of Chinese surgeons and their willingness to accept less than optimal operating conditions.” Bonica, “Acupuncture anesthesia,” 1324.

acupuncture anesthesia could be applied in the United States. He felt confident that American patients would not tolerate either the amount of preparation necessary before surgery nor the levels of discomfort experienced during surgery but was hopeful that researchers might find ways around these issues.

With respect to acupuncture's use as a general or pain-oriented therapy, Bonica was also keen to place the practice in historical and cultural context. As with acupuncture anesthesia, he was quick to note that Chinese acupuncture techniques could not be immediately implemented because "relief of pain and response to treatment" are strongly influenced by such factors as "tradition, education, background, and genetic[s]."⁶⁷ His white paper on the topic began by situating acupuncture within the "traditional medicine" of China with its own concepts for understanding the body, the universe, disease, diagnosis, and treatment.⁶⁸ Bonica also gave a brief account of the transformations that befell acupuncture in the twentieth century up until the Cultural Revolution. For these and other reasons, he insisted that acupuncture must "[conform] to current American public health policies and undergo experimental and clinical studies before permitting [its] widespread clinical use."⁶⁹

Physicians who sought more objective criteria for understanding pain also agreed that acupuncture could not be simply transplanted into American contexts without significant experimentation. Perhaps surprisingly, many Chinese practitioners supported this position. Bonica recounted that Chinese physicians advised care and

⁶⁷ Bonica, "Therapeutic acupuncture," 1551.

⁶⁸ Ibid

⁶⁹ Ibid, 1551.

caution when applying acupuncture in unfamiliar contexts. In fact, most of the medical delegations to China reported similar sentiments from their Chinese counterparts. For instance, here is an anecdote presented before the US Congress in 1979 by the anesthesiologist, M. T. “Pepper” Jenkins:

One physician said to me on the day we were leaving China, ‘Acupuncture is a wonderful, efficient, and reliable method for treating Chinese patients by skilled Chinese practitioners in Chinese hospitals. Because of the great ethnic and cultural differences between our countries, plus your professional liability insurance problems, you probably can’t make it work in America. Remember that ours is a strong and hardy race, who are stoic in the face of great adversity and complacent about personal discomfort, both of which have been woven into the fabric of our lives.’⁷⁰

Reports on the status of acupuncture in China by investigators like Bonica and Jenkins accurately reflected the lack of a consensus position as to the proper use of acupuncture within Chinese medical institutions. Acupuncture’s status in China was highly contested with even its advocates split about whether its practice should be based on traditional Chinese medical ideas, scientific innovation, or revolutionary ideologies. The Chinese government was deeply invested in their image of acupuncture as a symbol of

⁷⁰ Jenkins, M. T. “Status of Acupuncture in China and Comments of Applicability in the U. S. A.” Box 59, Folder 25. UCLA Special Collections: Bonica Papers. 13.

national progress but, still reeling from the upheaval of the Cultural Revolution and its aftermath, the medical community was unsure if and how acupuncture could be reintegrated into the healthcare system. American medicine, informed by delegations of scholarly exchange and committed to ongoing dialog with Chinese institutions, took the uncertainty of their colleagues in Asia to heart as well as their ambiguity around traditional concepts and their doubt that acupuncture would be effective beyond their national borders. In a letter to Bonica, the nationally renowned surgeon, Donald Effler framed his experiences observing acupuncture anesthesia in China very similarly:

I really do think that American medicine has given considerably more attention to acupuncture than it really deserves, and I believe that the initial stimulus for this does not come from our Chinese colleagues but from Chinese propaganda organs and from unqualified Western personnel, e.g., Reston (New York Times) whose opinions have little scientific value. Perhaps I am too rigid or too much of a reactionary to see much value in acupuncture as an anesthetic agent; however, I think I am a bit realistic when I suggest that it does have a place when properly used in China. I feel the same way about the African witch doctor who may occasionally be of real help to his patient whose cultural background is perhaps the lowest of all civilization -- I think it would be quite unfair to the dedicated witch doctor if we attempted to transplant him to the United States and expect Congo results.⁷¹

⁷¹ Effler, Donald. "Letter to John Bonica Dated August 14, 1974." Box 66, Folder 10. UCLA Special Collections:

In his response, Bonica claims to “agree wholeheartedly with every point” Effler makes.

By 1975, Bonica was withdrawing from the forefront of acupuncture inquiry. He seems to have made this decision because of health problems, other personal commitments, and the demands of his age. Yet even as late as 1988, he still believed that acupuncture had a future in medicine. In the second edition of his magnum opus, *The Management of Pain*, Bonica included a chapter on acupuncture.⁷² In a note to Richard Chapman, his colleague and author of the chapter, Bonica apologized for demanding a large number of edits and rewrites saying, “I realize that I am asking you to put more time on this paper, but it is a very important Chapter and it is necessary to present the concept in such a way as to minimize criticism by scientists and other leaders.”⁷³ In this aspiration, Bonica was not alone. Throughout the 70s American medicine remained quite hopeful that, given enough time and distance from the challenges of the Chinese context, acupuncture could be set firmly within their grounds.

The popular movement for acupuncture

Time and distance were not forthcoming, however. While the policy-makers of American medicine tried to keep acupuncture “experimental” until they could reach a

Bonica Papers.

⁷² Bonica, John J. 1990. *The management of pain*. Lea & Febiger.

⁷³ “Chapman, C. Richard. Chapter 90. Draft-Edited 3/88 for Management of Pain 2nd Edition.” n.d. Box 88, Folder 35. UCLA Special Collections: Bonica Papers.

consensus position, public and professional organizations quickly formed and seized on the tremendous popular support to make acupuncture therapy available. Acupuncture became a rallying point through which a variety of groups articulated disaffections with the system of medical practice and regulation at the time. Patient groups lobbied to direct the course of medical innovation towards disorders, like pain, that had been low on the list of medical priorities despite their high experiential toll.

James Reston's article in the *New York Times* is often cited as the decisive moment in which acupuncture captured the American public's imagination.⁷⁴ Yet it should be remembered that Reston received acupuncture as a means to remediate a side effect of surgery and described its practice as integrated into a Chinese hospital: "it is not exactly what the Rockefeller Foundation had in mind when it created the Peking Union Medical College, but like everything else in China these days, it is on its way toward some different combination of the very old and the very new."⁷⁵ Yet, even as Reston depicts a form of integration that was fairly similar to what American physicians sought, there is never any doubt that Reston's perspective is that of a patient. It should not be too surprising then that the article became a flashpoint for patient advocacy.

Meanwhile, different classes of health care practitioners saw in acupuncture an opportunity to challenge the medicolegal orders through which biomedicine dominated the system of health professions. These practitioners included members of the biomedical establishment who sought to develop new institutions, adherents to

⁷⁴ Reston, James. 1971. "Now, about my operation in Peking." *The New York Times*, July 26, 1971.

⁷⁵ Reston, "My operation in Peking," 6.

longstanding alternative medical ideologies such as chiropractic and naturopathic medicine, practitioners trained in or acclimated to practices of medicine in East Asia, entrepreneurs, and a host of other visionaries.

Professional and lay groups that formed to challenge the experimental status of acupuncture were varied and in many ways divergent in their beliefs of what clinical acupuncture should look like. Many of them did not last more than a decade and very few are still in operation today. Even so, their efforts put tremendous pressure on the state system of professions to recognize acupuncture and make it available. Kao and McRae describe how “in response to public pressure for acupuncture, and in defiance – sometimes open, often ‘underground’ – of the state medical boards, persons both foreign and American who are legally forbidden to practise acupuncture have proceeded to do so anyway, many setting up pain clinics, others holding ‘consultations’ in offices or even hotels.”⁷⁶ Linda Barnes describes an “anti-profession” of acupuncture in which “laypeople had begun to develop their own training programs, to set up practices, and to develop a strong popular following” and could be situated “as part of a broader cultural stance of resistance in the pursuit of alternative ideals.”⁷⁷

The counter-cultural resonance of acupuncture even emerged out of elements of the new left such as the Black Panthers and Young Lords. The cornerstone of this brand of revolutionary acupuncture was Lincoln Recovery, a community clinic operating out of Lincoln Hospital in the Bronx that sought to redress the health concerns of otherwise

⁷⁶ Kao and McRae, “Chinese medicine in America,” 268.

⁷⁷ Barnes, Linda L. 2003. “The acupuncture wars: The professionalizing of American acupuncture-a view from Massachusetts.” *Medical Anthropology* 22 (3): 261–301. 270.

underserved populations. In July of 1970, the Young Lords and the Health Revolutionary Unity Movement (HRUM) staged an armed takeover of Lincoln Hospital and demanded the transformation of an institution they felt was “more preoccupied with the testing of new medical equipment, training of medical students, and continued payment of the city government for running the health center than with helping patients.”⁷⁸ The community collective that resulted from this takeover led to the development of a drug detoxification program and, as early as 1973, to acupuncture. At Lincoln, the same traits that had made acupuncture compatible with Chinese revolutionary ideologies decades earlier and had appealed to itinerant physicians a century before that were brought to the fore. The collective began to use acupuncture based on the drug detoxification protocol of Dr. Wen in Hong Kong but quickly expanded it in associating with therapeutic concepts of self-regulation and natural healing.⁷⁹ All of these factors challenged the medical and professional regulatory mechanisms of states to find a way to incorporate acupuncture.

Despite very different ideas about what culture was and how it worked, it became a focal point in the struggle to find a legitimate basis for acupuncture. Many figures in the medical establishment (perhaps best represented in positions advocated by the AMA) saw culture as challenging established modes of evaluation deployed by biomedicine. For them, culture was either a complicating factor that required controlled study or the crutch of tradition that supported the continued practice of this otherwise

⁷⁸ "The Lincoln Hospital offensive", *Latino Education Network Service*, <http://palante.org/04LincolnOffensive.htm> (accessed November 16, 2014).

⁷⁹ Mitchell, Ellinor R. 1995. *Fighting drug abuse with acupuncture: The treatment that works*. Pacific View Press Berkeley.

ineffective therapy. Others more critical of the status quo, including members within the medical community, saw culture as the basis for new perspectives, concepts, and frameworks of knowledge on which acupuncture practice could be established. They generally argued that acupuncture expertise found its theoretical foothold in Chinese medicine, a specialized form of knowledge that was culturally distinct from and therefore not recognized by biomedical institutions of the time. They argued before the state(s) that a learned profession of acupuncture could be established, practiced, transmitted via educational institutions, and regulated as a form of Chinese medicine.

Interest in acupuncture became sharply polarized. Medical institutions demanded time to better understand and evaluate its mechanisms. Practitioner and lay groups saw medical investigation as causing unnecessary delay. In many corners of the media, the debate was portrayed as one between the reactionary and self-protective forces of the medical establishment on the one hand and a more cosmopolitan and progressive public on the other. Bonica too was not immune to this dynamic and watched with dismay as his ideas were transformed and thrown back at him by the press and public. In 1974, he was flooded with letters from all over the country as a result of a widely published Associated Press (AP) article that attributed to him the statement that “acupuncture may have some value as an anesthetic, but appears to have no value as treatment for disease.”⁸⁰ In a handwritten letter to Bonica, one woman describes her mother’s struggle with Multiple Sclerosis:

⁸⁰ *The Washington Post (1974-Current File); Washington, D.C.* 1974. “Acupuncture as cure is questioned,” June 17, 1974. A20

She has consulted doctors, therapists and the Multiple Sclerosis Society for help and they have all but slammed the door in her face. She has also tried[sic] special diets, vitamins, physical therapy, etc., etc., nothing, no help at all... As far as I am concerned, doctors with the A.M.A. and all else literally turning their backs on us we have turned our faith to acupuncture. It is helping my mother. There is a noticable[sic] improvement in her handwriting, she feels better and looks healthier.⁸¹

Bonica received so many similar letters that he drafted a form letter for responses. In it, he said that the AP report contained “serious misrepresentations of my opinions about acupuncture.” Bonica wrote several letters to the AP and media outlet chastising them for misrepresenting his position but the impression of obstructionism stuck.

First-hand experience and Nevada legislation

This sense of biomedical resistance was especially acute for those who had encountered acupuncture first-hand and walked away with an experience of therapy that felt comprehensive rather than merely experimental. In 1973, Nevada legalized acupuncture for non-physicians. As Arthur Yin Fan has shown, the argument for the

⁸¹ Ruskavage. “Letter to John Bonica Dated June 17, 1974.” Box 66, Folder 10. UCLA Special Collections: Bonica Papers.

legislation was most persuasively made not by articulating traditional ideas or critiquing medical norms but through Yee Kung Lok's temporary clinic set up across from the legislative building.⁸² Over the course of three weeks, Lok treated over 700 patients including "more than 20 legislators... their illnesses varying from back pain to ulcers."⁸³ A lobbyist for the bill, Jim Joyce, "recalled he suddenly found himself in the position of conversion, as a lot of legislators approached him for help, asking whether Dr. Lok could treat their wife, wife's mother or the less fortunate."⁸⁴ *Time* reported that "scores of constituents begged their representatives to get appointments for them at the clinic."⁸⁵ In the light of their experiences and in the face of public desire to receive treatment, lawmakers lost patience with the physicians of the Nevada State Medical Association (NSMA). Fan describes how, in response to the NSMA president's position that more time was required to understand acupuncture's potential risks and benefits, one congressman interrupted saying "you medical doctors have intentionally delayed the legislature, we will show you how things should be run."⁸⁶ The chairman of the committee meeting as if to make this lack of patience more literal immediately reminded the physicians that, "you only have 30 minutes to talk, hurry up."⁸⁷ The law soon passed that created licensure for non-physician acupuncturists and located its basis in the expert knowledge of Chinese medicine.

⁸² Fan, Arthur Yin. 2015. "Nevada: The first state that fully legalized acupuncture and Chinese medicine in the United States." *Journal of Integrative Medicine* 13 (2): 72-79.

⁸³ Fan, "Nevada," 75.

⁸⁴ *Ibid*, 75.

⁸⁵ *Time*. 1973. "Acupuncture in Nevada," 1973. 16.

⁸⁶ Fan, "Nevada," 76.

⁸⁷ *Ibid*, 76.

By the end of the 1970s, the lay public and state systems of professional regulation had also lost patience with the AMA's position, which was now becoming more and more widely regarded as a tactic of delay and control for the sake of the profession and against the public interest. In a rebuttal of the earlier mentioned Jenkins testimony before the US Congress, the acupuncturist Yeh-chong Chan wrote, "if Dr. Jenkins' recommendations were interpreted and applied literally throughout the United States, patients seeking acupuncture treatment would effectively be denied access to it, since so few, if any physicians have been or are now being properly trained in its use. This result [is] tantamount to a ban on acupuncture"⁸⁸

Legal actions against acupuncturists for practicing medicine without a license also stirred up public sentiment and propelled lobbying efforts in states like New York and California. Ironically, many of these cases ended up reinforcing acupuncture status as a modality of Chinese medicine even when legal arguments sided with the medical establishment that acupuncture was still a "practice of medicine" and fell within their mandate. For instance, a law review article from 1976 summarizing the case for treating acupuncture as an illegal practice of medicine used a cultural definition of acupuncture calling it "an ancient method of Chinese therapy" while mentioning but not relying on the medical definition of acupuncture as "the selective stimulation of the body's neurological and defense mechanisms by the insertion of needles in an effort to correct neuromuscular and organic disorders and to induce analgesia."⁸⁹ While the popular

⁸⁸ U.S. Congress. House. Committee on Subcommittee on Science, Research, and Technology. *U.S.-China Science Cooperation*. 91st Cong., 1st sess., May 7-8, 10, Jun. 22, 1979. 278.

⁸⁹ Danne, William H. 1976. "Acupuncture as illegal practice of medicine." *American Law Reports*.

movement grew, the aspiration to bring acupuncture into biomedicine was losing steam. Once the technique proved impractical and unreliable for anesthesia, excitement diminished significantly. The biological mechanisms of acupuncture remained undetermined as did a rationale for how it could be fit into the system of medical specialties.

Conclusion: The hegemony of culture (1980-present)

In this chapter, I have described how acupuncture was reintroduced to the United States in 1971 and received widespread attention. At first, the medical community hoped to incorporate acupuncture into their practice of medicine and treated it as a medical innovation. Though elements of American medicine were hostile to acupuncture, most were quite positive and the overall position was one of uncertainty that was congruent with the healthcare system of the PRC. However, as the public and the nascent acupuncture profession pushed to make acupuncture available, positions polarized and the medical establishment came to be seen in opposition to popular movements. In the course of this struggle, an image of Chinese medicine was articulated through medico-legal venues and media sources. This image came to serve as both an “alternative” framework for legitimizing acupuncture and as a critique of biomedical authority. Proponents argued that acupuncture could not be properly evaluated by biomedicine because it was the product of a foreign culture. Yet, the

medical establishment claimed that acupuncture should be labeled as experimental exactly because it had been developed for use in a foreign culture and the proper means for translated into the United States were not understood. Although different groups deployed different notions of culture, the broader idea became a common currency. Ultimately, cultural difference became the measure by which acupuncture was differentiated from biomedical practice.

Since that time, the cultural approach to acupuncture has attained hegemony with the gradual expansion of acupuncture schools, state and national credentialing programs, national research centers, and legal regimes each of which relies on the fact that acupuncture uses concepts and knowledge derived from Chinese medicine (or sometimes on a broader notion of East Asian medicine). Take, for example, this “definition” of acupuncture as legally given by the State of Florida’s Department of Health:

“Acupuncture” means a form of primary health care, based on traditional Chinese medical concepts and modern oriental medical techniques, that employs acupuncture diagnosis and treatment, as well as adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease.⁹⁰

The definition says nothing about needles and makes no reference to anatomy or

⁹⁰ Andrews v. Ballard, 498 F. Supp. 1038 (S.D. Texas, Houston Div.), 1980.

physiology. The terms “Chinese medicine” and “oriental medicine” are instead given as the formal basis of acupuncture in Florida.

Even Frederick Kao, the physiologist who, in the 1973 NIH acupuncture conference, had said that yin and yang might be left to historians because they had no basis in physiological activities and did not contradict his colleague’s statement that such notions were “merely an exotic, philosophical explanation used to tie a number of practical observations together,” rearticulated his position:

In the United States, tragically, biomedical practitioners whose scientific training might have been expected to send their minds down paths of open inquiry—instead find themselves entrenched in a state of blindly dogmatic opposition to traditional Chinese medicine engendered by their scientific objections to the theory. Unable to accept the theory of acupuncture, for example, they reject the practice, ignoring all evidence of its efficacy. In effect, they have thrown the baby out with the bath water. Forestalling any exploration of acupuncture's benefits until an acceptable theory has been found, they (to change the metaphor) put the cart before the horse, worrying about acupuncture's mechanism before bothering about when to use it. Few are the American physicians and laboratory researchers who are able to accept acupuncture theory as having pre-dated the scientific method, who are willing to use it, following principles that work—even if or the wrong reason—all the while searching for an explanation of something so far not fully explicable. So

far as acupuncture is concerned, the American scientist's spirit of pragmatism seems mostly dead.⁹¹

My interest in telling this history of acupuncture has been, like Kao, to reinvigorate a spirit of pragmatism with respect to acupuncture. In the social sciences, such reinvigoration requires critical reevaluation of the status of acupuncture vis-a-vis both Chinese medicine and biomedicine. For hundreds of years, acupuncture has been a bit player in the practice of Chinese medicine in China yet these terms have become almost synonymous in the American context. Here acupuncture has come to be considered Chinese medicine not under the weight of its history but under the specific historical circumstances of its reception in the 1970s and 80s. I have argued that acupuncture's association with Chinese medicine was less a matter of medical principle than of legal convenience. Patients demanded that acupuncture be made available and biomedical institutions were not ready or willing to do so.

Perhaps nowhere is this clearer than in the *Andrews v Ballard* decision of 1980 regarding the practice of acupuncture in Texas. In it, plaintiffs successfully argued that existing medical regulations unnecessarily restricted access to the acupuncture. In her opinion, the judge refused to class acupuncture as a medical innovation. Acupuncture, she wrote, "is no more experimental as a mode of medical treatment than is the Chinese language as a mode of communication. What is experimental is not acupuncture, but

⁹¹ Kao and McRae, "Chinese medicine in America," 266.

Westerners' understanding of it and their ability to utilize it properly."⁹² This legal argument rests on an almost textbook definition of cultural difference. Yet to deny the experimental aspect of a system of language or practice is to deny its ability to emerge out of life in the contemporary moment. This position is especially problematic if carried into social scientific analysis.

My argument concerning the role of culture in acupuncture is quite similar to one that Sean Hsiang-lin Lei makes with respect to experience (jingyan) in Chinese medicine.⁹³ Lei shows that Chinese medicine became a "medicine of experience" as a result of political debate rather than as an articulation of clinical reasoning. He argues that although the jingyan concept may help to track the movement of Chinese medicine through various "political-medical situations," it "cannot be used as an effective analytic tool in an attempt to understand the actual practice of Chinese medicine" because "it reveals more about Chinese medicine's self-positioning toward Western medicine than about Chinese medicine itself."⁹⁴ While I feel that Lei's proscription is too strenuous in its rejection of the experiential foundations of Chinese medicine, I agree that scholarship must be conscientious of the difference between political-medical contexts and those of the clinical encounter. Similarly, I would like to differentiate between the reasoning of public and legal spheres used to make acupuncture available and the patterns of practice that have sustained acupuncture. Concepts that assume cultural difference (whether through clashing or crossing) work best when analyzing the formal

⁹² *Andrews v. Ballard*, 498 F. Supp. 1038 (S.D. Texas, Houston Div.), 1980.

⁹³ Lei, Xianglin. 2002. "How did Chinese medicine become experiential? The political epistemology of jingyan." *Positions: East Asia Cultures Critique* 10 (2): 333–364.

⁹⁴ Lei, "How did Chinese medicine become experiential?," 358.

positions of institutions, regulatory and legal regimes, and the public image of acupuncture. They should not be uncritically applied to understand how acupuncture works in practice or what people get out of it. The separation need not be complete but at the very least a space of play should be introduced between the clinical encounter and their institutional formalizations if for no other reason than to understand the ways in which they interpenetrate one another.

Conclusion:

Creativity, action, and embeddedness

In October of 2007, Nobuari Takakura and Hiroyoshi Yajima published that they had successfully developed a “placebo needle” capable of masking (blinding) both patients and clinicians as to whether the acupuncture being performed in a clinical research trial was “real” or “sham.” To justify their innovation, Takakura and Yajima contended that “double-blind trials using placebo needles are critically important to ensure that acupuncture research meets the methodological standards of medical science to provide stronger evidence of the effectiveness of treatment using needles.”¹ But, why would anyone expect better evidence to come from a trial in which practitioners cannot determine whether or not they are actually doing acupuncture?

Among the works that Takakura and Yajima cite to support their claim is a series of letters published in *JAMA*² discussing issues around appropriate masking in a particular clinical trial.³ One letter asserted that the study’s results revealed more about the effectiveness of placebo than of acupuncture because the blinding methods were inappropriate. Better masking could be achieved, according to this letter-writer, if experienced clinicians were replaced with untrained individuals taught to conduct

¹ Takakura, Nobuari, and Hiroyoshi Yajima. 2007. “A double-blind placebo needle for acupuncture research.” *BMC Complementary and Alternative Medicine* 7 (1): 31.

² Kaptchuk, Ted J., Erica Frank, Joannie Shen, Neil Wenger, John Glaspy, Ron D. Hays, Paul S. Albert, Christina Choi, and Paul G. Shekelle. 2001. “Methodological issues in trials of acupuncture.” *JAMA* 285 (8): 1015–1016.

³ Shen, Joannie, Neil Wenger, John Glaspy, Ron D. Hays, Paul S. Albert, Christina Choi, and Paul G. Shekelle. 2000. “Electroacupuncture for control of myeloablative chemotherapy-induced emesis: A randomized controlled trial.” *JAMA* 284 (21): 2755–2761.

acupuncture only for the purposes of the trial or if the acupuncturists remain uninformed about the desired study outcomes. The authors of the original study replied:

When evaluating any intervention of unknown efficacy, particularly manual or surgical, it is prudent for skilled clinicians to administer the intervention. To do otherwise would make the interpretation of a negative result problematic—is the intervention really without benefit, or was the lack of effect due to the use of inexperienced or unskilled clinicians?⁴

What is fascinating to me about the development of a “placebo needle” and the concerns over evidence and interpretation that lead up to it is how otherwise well-known methodological issues around the standards of evidence for the efficacy of complex therapeutic interventions are being presented as if for the first time. With respect to surgery, David Jones has demonstrated that surgeons, “like other physicians, have many ways to gauge the efficacy of their operations, including both theory (i.e., is it likely that the operation could work?) and empirical observation (i.e., what outcomes did the surgery produce?), documented through testimonials, case reports, case series, and formal clinical trials.”⁵ Debates in Western medicine over evaluating surgical interventions are long-standing. They reach back to the days when surgeons went from

⁴ Kaptchuk et al, “Methodological issues,” 1016.

⁵ Jones, David S. 2018. “Surgery and clinical trials: The history and controversies of surgical evidence.” In *The Palgrave Handbook of the History of Surgery*, 479–501. Springer. 480.

being craftsmen to medical professionals and are at least as old as the very inception of the idea of the randomized clinical trial as a gold standard of medical evidence.⁶ Even today, surgical trials face many of the same methodological problems as they increasingly fall under the rubric of evidence-based medicine.

An even more revealing precedent can be found in psychotherapy. Throughout the twentieth century, research psychotherapists have made various attempts to fit the practice to the RCT model. In fact, the notion of distinguishing between specific and nonspecific components of therapy gained prominence in the context of methodological concerns about psychotherapeutic techniques in the 1950s.⁷ In a paper published in 1986 refuting the utility of notions such as placebo, specificity, and blinding for psychotherapy, Stephen Butler and Hans Strupp point out certain fairly obvious differences between psychotherapeutic interventions and more “mechanical” models of medicine. Their claims are remarkably similar to those that have been made about acupuncture in the last decade.

Psychotherapy is not a medical technology that can be administered mechanically to a passive patient, and that somehow eradicates an illness or syndrome, leaving the patient “cured.” ... Pharmacological research uses placebo-control designs to take advantage of the generally stark contrast between physiological biochemical and social-symbolic phenomena. In psychotherapy

⁶ Jones, “Surgery and clinical trials.”

⁷ Rosenthal, David, and Jerome D. Frank. 1956. “Psychotherapy and the placebo effect.” *Psychological Bulletin* 53 (4): 294.

research, these designs are inappropriate because there is no such contrast.

Indeed, psychotherapeutic technical (specific) factors must be defined with reference to the same symbolic and interpersonal realm which defines the relationship (nonspecific) factors.⁸

Butler and Strupp conclude that investigations of psychotherapy could be made much more clinically relevant if they eschew “disembodied” or “decontextualized” accounts and instead “begin with the concrete events as they occur in a particular therapeutic relationship.”⁹ In a sense, this suggestion is taken up by this dissertation with the aim of describing the social, experiential, and interpersonal qualities of acupuncture’s activity as well as its embeddedness in the larger context of American medicine.

From the repudiation of knowledge (chapter 1) to the rejection of the need for physiological theory (chapter 2), the decentering of the needle as a technology that sets upon an object (chapter 3), a reluctance to adopt stereotypes of diagnostic language (chapter 4), and to the appearance of Chinese medicine as a medico-legal category rather than a basis of clinical reasoning (chapter 5), I have shown various ways in which acupuncture also does not fit the model of a medical technology that can be, as Butler and Strupp state, “administered mechanically to a passive patient.” The idea that acupuncture does not fit such a model of therapeutic action has, to an extent, been the starting point for many anthropologists, historians, and other social scientists interested

⁸ Butler, Stephen F., and Hans H. Strupp. 1986. “Specific and nonspecific factors in psychotherapy: A problematic paradigm for psychotherapy research.” *Psychotherapy: Theory, Research, Practice, Training* 23 (1): 30-40. 32-33.

⁹ Butler and Strupp, “Specific and nonspecific factors,” 38.

in the topic. However, as I hinted at in the introduction and in chapter 1, scholars too often look to resolve this problem by introducing Chinese medical concepts, bodies of knowledge, and institutional structures into the rational/mechanical model of therapeutic action rather than questioning the underlying theory of action on which the model depends. Yet, so much of what the patients and practitioners with whom I did my fieldwork find valuable in acupuncture is a matter not of mechanical action but of reaction, response, and reflection; not of medical logics but of dialogics; not of culturally inflected rationality but of relationality. In each chapter, I try not just to refute rational models of therapeutic action but replace them with a range of frameworks for understanding therapeutic activity: an awareness premised on not-knowing (chapter 1), the experientially-oriented category of practical medicine (chapter 2), the rhythms and reverberations that constitute a poetics of space (chapter 3), the emergent features of language and expressibility of the illness experience (chapter 4), and the use of notions of culture to acknowledge the conditions and contexts of therapy (chapter 5).

It has not been my goal to reveal the true or proper basis of acupuncture. Instead, I try to give a sense of just how diverse and theoretically flexible acupuncture practice has been. Published clinical research from Joyce Hughes,¹⁰ Charlotte Paterson,¹¹ Paterson and Nicki Britten,¹² Timothy Robinson,¹³ and Fiona Barlow et al¹⁴ have shown

¹⁰ Hughes, Joyce G. 2009. "When I first started going I was going in on my knees, but I came out and I was skipping': Exploring rheumatoid arthritis patients' perceptions of receiving treatment with acupuncture." *Complementary Therapies in Medicine* 17 (5-6): 269-273.

¹¹ Paterson, Charlotte. 2007. "Patients' experiences of Western-style acupuncture: The influence of acupuncture 'dose', self-care strategies and integration." *Journal of Health Services Research & Policy* 12 (1_suppl): 39-45.

¹² Paterson, Charlotte, and Nicky Britten. 2008. "The patient's experience of holistic care: Insights from acupuncture research." *Chronic Illness* 4 (4): 264-277.

¹³ Robinson, Timothy W. 2012. "Western acupuncture in a NHS general practice: Anonymized 3-Year patient

that acupuncture can be practiced effectively using a “Western” style as is found particularly within the British National Health Service (NHS). In her study of Western-style acupuncture Paterson concludes that, though patients described widely differing experiences of acupuncture and a majority reported having complete or partial relief of symptoms, “the patients who benefited most were those with good general health and a single source of pain and disability.”¹⁵ This finding speaks not only to the diversity within acupuncture practice but to the futility of attempting to confine acupuncture to the act of needling without also considering the broader context in which such therapeutic actions are situated. American acupuncture is not just a modality of East Asian medicine: it can be biomedicine too.

Creative therapeutic activity

The difference between the rational/mechanical model of therapeutic action operative in RCTs and the kinds of “holism” attributed to East Asian styles of acupuncture can be seen as part of a much broader history of conflict within the scientific community about what it means to do science. Anne Harrington, in her book on German holistic science, presents a history in which the “machine society” touted by Hermann von Helmholtz, Emil Du Bois-Reymond, and Rudolf Virchow was critiqued and opposed in the early

feedback survey.” *The Journal of Alternative and Complementary Medicine* 18 (6): 555–560.

¹⁴ Barlow, Fiona, Clare Scott, Beverly Coghlan, Philippa Lee, Peter White, George T. Lewith, and Felicity L. Bishop. 2011. “How the psychosocial context of clinical trials differs from usual care: A qualitative study of acupuncture patients.” *BMC Medical Research Methodology* 11 (1): 79.

¹⁵ Paterson, “Patients’ experiences of Western-style acupuncture,” S1:44.

twentieth century by a group of German-speaking scientists.¹⁶ She introduces this science of wholeness in a moment of reflection on Max Weber's lecture on science as vocation and through the epistemological and social disorientation that followed in the wake of World War I.

These men—biologists, neurologists, and psychologists—argued that a continuing commitment to responsible science *was* compatible with an ethically and existentially meaningful picture of human existence; but only *if* one were prepared to rethink prejudices about what constituted appropriate epistemological and methodological standards for science. Under the banner of Wholeness, these scientists argued, in varying ways, that a transformed biology and psychology—one that viewed phenomena less atomistically and more “holistically,” less mechanistically and more “intuitively”—could lead to the rediscovery of a nurturing relationship with the natural world. What the old science of the Machine had wrought, a new science of Wholeness would heal. It would “reenchant” the world.¹⁷

A disaffection towards machine society characterized not just the natural sciences but much of the social and human sciences as well. Hans Joas, in a rigorous and complex investigation of sociological theories of action, traces it back into the philosophic and

¹⁶ Harrington, Anne. 1999. *Reenchanted science: Holism in German culture from Wilhelm II to Hitler*. Princeton University Press. emphasis hers.

¹⁷ Harrington, *Reenchanted science*, xvi.

social scientific disciplines of the nineteenth century and then forward to the end of the twentieth.¹⁸ Joas shows how philosophers and social theorists from Johann Gottfried Herder to Karl Marx, Emile Durkheim, Arthur Schopenhauer, and Georg Simmel critiqued rationalist and normative models of social life for their lack of emphasis on what Joas deems the “creative” dimensions of human action. Published in German in 1992, Joas’ text was not simply a reflection on the history of a theme in sociological analysis. It also revealed how conflicts between rationality and creativity had not yet been resolved. Joas ultimately attempts to lay the foundations for a more robust and far-reaching theory of action, one based on identifying the forms of creativity at play rather than looking for rationalities followed or norms being embraced.

This dissertation can be seen as extending Joas’ work in two distinct ways. First, it brings his claims in line with the concerns of medical practice. Joas identifies three limiting assumptions of rational models of action: “they presuppose firstly that the actor is capable of purposive action, secondly that he has control over his own body, and thirdly that he is autonomous vis-a-vis his fellow humans.”¹⁹ These assumptions are equally present in the drive to identify therapeutic specificity. The need to question these assumptions is perhaps obvious with respect to concerns over masking the participants in RCTs of acupuncture. However, in a much broader sense, it is worth thinking about the creative components that operate within any medical action.

Acupuncture is a particularly useful window on such theories of action because

¹⁸ Joas, Hans. 1996. *The creativity of action*. University of Chicago Press.

¹⁹ Joas, *The creativity of action*, 147.

of the way that the idea of Chinese medicine is used to relieve the tension between the rational and the creative without resolving it. Chinese medicine offers forms of rationality and norms of practice that are more open to both creative and practical interpretations. This is in part because Chinese medical concepts like blood and qi are far more open than their biomedical counterparts. But, it is also because the “foreignness” of Chinese medicine means that the proper context of practice is constantly being reevaluated.

As I suggest in chapter 1 and 5, medico-legal institutions extend legitimacy to acupuncture on the basis of a rational model of its therapeutic actions. Without the cover of Chinese medicine, the non-rational aspects of practice would be at risk of being construed as irrational and become more vulnerable to accusations of quackery and, perhaps no less nefarious, of falling into the self-deceptive snare of placebo effects. The legitimacy of Chinese medicine as a medical system is often built on an analogy to the foreignness of a language. The judge in the *Andrews v. Ballard* case described in chapter 5 is able to assume that acupuncture has a rational basis even if she cannot speak to what it is: “[acupuncture] is no more experimental as a mode of medical treatment than is the Chinese language as a mode of communication. What is experimental is not acupuncture, but Westerners' understanding of it and their ability to utilize it properly”²⁰—as if the Chinese never experiment with their own language. On the other hand, the material conditions that hone the poetry of language are often more easily grasped by those not distracted by the meaning of the words. Virginia Woolf, for

²⁰ *Andrews v. Ballard*, 498 F. Supp. 1038 (S.D. Texas, Houston Div.), 1980.

instance, writes that “foreigners, to whom the tongue is strange, have us at a disadvantage. The Chinese must know better the sound of *Antony and Cleopatra* than we do.”²¹ The foreignness of American acupuncture brings the creativity inherent in all therapeutic activities to the fore.

In addition to thinking about creative action in the context of medicine, this dissertation also suggests the need to reexamine Joas’ argument in the context of anthropological and ethnographic theory. Joas’ theory engages primarily with sociology and philosophy. Anthropological concerns are related but distinct. Take, for example, E. Evans-Pritchard’s comments on Zande beliefs in witchcraft:

Even to the Azande there is something peculiar about the action of witchcraft... Indeed, I have frequently been struck when discussing witchcraft with Azande by the doubt they express about the subject, not only in what they say, but even more in their manner of saying it, both of which contrast with their ready knowledge, fluently imparted, about social events and economic techniques... In truth Azande experience feelings about witchcraft rather than ideas, for their intellectual concepts of it are weak and they know better what to do when attacked by it than how to explain it. Their response is action and not analysis... The Zande actualizes these beliefs rather than intellectualizes them, and their tenets are expressed in socially controlled behaviour rather than in doctrines. Hence the difficulty of discussing the subject of witchcraft with Azande, for their

²¹ Woolf, Virginia. 2009. “On being ill.” In *Selected Essays*, 101–10. Oxford University Press.

ideas are imprisoned in action and cannot be cited to explain and justify action.²²

Evans-Pritchard specifically says that one cannot look to Zande ideas in order to explain or justify the actions taken with respect to witchcraft. What he seems to be reaching for instead is a non-rational theory of action. Yet, the reception of Evans-Pritchard's text and the ensuing debates in anthropology tended to focus on questions of rationality and the problems of relativism as they arise in different social contexts.

The disagreements about cultural and social relativism that characterized models of rationality in anthropology were related but quite different from those that Joas describes in sociological theory with their indebtedness to economic models of rational action. Anthropological concern with such things as myth, magic, and ritual activity also point to an aspect of creative action that Joas mentions but does not fully develop. Joas notes that rational and normative theories of action focus on evaluating the range of possible actions while fixing the context on which those actions take place. As Joas puts it, "*first* orientation is found through cognizance of the world, only *then* to be followed by action."²³ Yet anthropologists and ethnographers have long been attentive to instances that work the other way around, cases in which context emerges in response to reorienting actions. The purpose of a ritual action may not be to achieve a result under a given set of conditions but to transform the very conditions and contexts in which the ritual action is placed.

²² Evans-Pritchard, E. E. 1976. *Witchcraft, oracles, and magic among the Azande*. Oxford: Clarendon Press. 31.

²³ Joas, *The creativity of action*, 157.

The embeddedness of concrete experience

Throughout this dissertation, I have given very little direct attention to that most iconic act of acupuncture, the insertion of a needle into the body. This is not because I find the act unimportant or seek to decenter it. Quite the contrary, my ethnography tries to stay as close to the act of needling as possible. The main reason that I avoid direct description and analysis is because the needle tends to trigger particular habits of interpretation that make it difficult to get a balanced view of how it is embedded into larger contexts. The acupuncture needle is too easily caught in a system of medical expertise. A particular model of its therapeutic action is built into the curricula of acupuncture schools and regulatory bodies at the state and national level. Under this framework, the needle and its specific effects become an instrument under the control of a healthcare professional. Furthermore, the interpretation of the acupuncture needle has, for decades, been bound to ideas of cultural difference. In the United States, acupuncture has become deeply associated with Chinese and East Asian medicines to the point that it is difficult to talk about one without talking about the other. These frameworks are not incorrect but they are partial and in many cases not particularly significant. In this dissertation, I have tried to demonstrate that understanding the mechanisms and effects of acupuncture requires much more open lines of interpretation.

Two characteristics of acupuncture stand out: theoretical flexibility and the ability to draw attention to concrete experiences. In thinking about these two aspects of acupuncture as they appear throughout these chapters, I have found myself turning and returning to Marcel Mauss' notion of "total social facts" (or "total social phenomena") and especially Claude Levi-Strauss' reading of the concept. Mauss, in attempting to understand the social workings of gift-giving, considers his method to be about "posing questions to historians and ethnographers, and putting forward subjects for enquiry rather than resolving a problem and giving a definitive answer."²⁴ This manner of posing questions means not simply reducing gift-giving to a form of economic exchange but recognizing that it is "at the same time juridical, economic, religious, and even aesthetic and morphological, etc."²⁵ The "total" view for Mauss is not one that sees all but one that sees "what is essential, the way everything moves, the living aspect, the fleeting moment when society, or men, become sentimentally aware of themselves and of their situation in relation to others."²⁶ Levi-Strauss, in his reading of Mauss, conceptualizes such fleeting moments as crossroads linking the social to the individual and the physical/physiological to the psychological.²⁷ Navigating these crossroads requires two very different systems of orientation. On the one hand, there are the collective systems of signification and, on the other, the grasp of concrete experience that confirms that these significations correspond "to reality, rather than

²⁴ Mauss, Marcel. 1990. *The gift: The form and reason for exchange in archaic societies*. London: Routledge. 100.

²⁵ Mauss, *The gift*, 101.

²⁶ Ibid, 102.

²⁷ Levi-Strauss, Claude. 1987. *Introduction to the work of Marcel Mauss*. Translated by Felicity Baker. Routledge. 26.

being an arbitrary accumulation of more or less true details.”²⁸ This way of conceptualizing the total social fact seems to fit very well with acupuncture. Acupuncture’s theoretical flexibility means that it can accommodate a number of different systems of signification. Furthermore, its ability to direct attention to concrete experience means that it also corresponds to some sense of reality.

I have dedicated much of this dissertation to aspects of concrete experience: feelings, and forms of awareness and sensation. I have put less emphasis on what Levi-Strauss calls “different modes of the social (juridical, economic, aesthetic, religious and so on)”²⁹ and the ways in which acupuncture is embedded in these aspects of social life. In chapters 1 and 5, I speak to juridical elements. Chapter 3 examines questions of aesthetics. Chapter 4 discusses issues of language and communication. As an exercise in tracing further modes of social embeddedness, I want to provide a very bare sketch of some of the economic and spiritual concerns around acupuncture in the United States. If concrete experience gave a glimpse of the creativity of practice than these kinds of social frameworks can give a sense of how acupuncture fits into the landscape of American medicine.

Looking at the economic modes of the social life woven into acupuncture, for example, it becomes important to realize that clinical practices tend to be privately-run businesses that rely on cash transactions. They are owned and operated by the acupuncturists who work in them. Regardless of what might be said of the difference

²⁸ Levi-Strauss, *Introduction to the work of Marcel Mauss*, 27.

²⁹ *Ibid*, 26.

between biomedical and East Asian medical concepts, one of the most striking differences between these practice models in the United States is the degree to which services are transparently priced and paid for in or around the time of service in a direct cash exchange between the business-practitioner and the customer-patient. William Bowen, writing on the history of discourse in and around Chinese medicine in the United States cites the medical market as among the most influential forces of change. His analysis shows how transformations in the language of Chinese medicine cannot be understood strictly as a result of an encounter with the “objective” truths of biomedicine or of abstract notions of cultural translation but “as a reflection of the need to *survive as a viable business* in a new cultural context,” one that brings the value of “doctor-patient interactions” to the fore.³⁰ Bowen notes how graduates of American acupuncture schools felt that their education had overemphasized the importance of learning the treatment principles of Chinese medicine while undervaluing the skills necessary to run one’s own business. The concern has become perennial. Acupuncturists I encountered in my fieldwork some 20 odd years after Bowen almost all recommended that acupuncture schools incorporate more entrepreneurial skill training into their curriculums. These concerns reveal the value of framing acupuncture as an entrepreneurial activity that operates in the contexts of an economy of market transactions. The embeddedness of acupuncture in the United States has a great deal to do with its ability to survive as a collection of small businesses in a medical market

³⁰ Bowen, William. 1993. “The Americanization of Chinese medicine: A discourse-based study of culture-driven medical change.” PhD diss., University of California, Riverside. 556-557. emphasis mine

dominated by massive institutions.

Emily Wu's recent study of practitioners in the San Francisco Bay area highlights how questions of spirituality and religion also provide significant insights into the ways in which Chinese medicine has transformed within the American context.³¹

Approaching Chinese medicine and acupuncture practice from a religious studies perspective, Wu argues that the use of terms like 'qi' evince forms of "embodied spirituality." She tracks how different commitments to the spiritual side of the practice transverse religious and secular domains. She also shows how the spiritual aspects of treatment have evolved out of a long history of ritual and religious healing in China but also make sense in the context of contemporary differences in the role of religious ideas between the People's Republic of China and the United States. In direct opposition to the Westernized view of the mystic East as a spiritual land, Wu notes that modern Chinese history is marked by a resistance to superstitions in which "many of the spiritual and religious ideas, behaviors, and practices were vehemently rejected as primitive and counterproductive to the advancement of the Chinese civilization."³² In the United States, on the other hand, acupuncture is often touted as a treatment for "mind, body, and spirit." Foundational figures in American institutions of acupuncture Miriam Lee and James Tin Yao So wore their Christian identities on their sleeves and portrayed a commitment to the future of American acupuncture that overtly invoked Christian calls to mission service.

³¹ Wu, Emily S. 2013. *Traditional Chinese medicine in the United States: In search of spiritual meaning and ultimate health*. Lexington Books.

³² Wu, *Traditional Chinese Medicine in the United States*, 171.

In her well known clinical guide to acupuncture theories and techniques, Lee writes of treating a woman with numbness in her fingers and “possible multiple sclerosis.” After describing the acupoints she used and the rationale behind them, Lee adds that:

I advised this woman to sing. Not sad songs but hymns of praise. To sing them out loud, not just hum, paying attention to the words. The issue in this woman’s case was, in part, a spiritual one. Besides the fact that singing does wonders for the lungs and circulation, the words serve as a reminder of the wonders of creation that are all too easily forgotten in the face of hurt and disappointment. Asking the Lord’s help in letting go of old habits and fears brings us to a strength greater than our own. Nothing is really worth the slow dying that results from hanging on to old hopes and negative feelings, but human beings unfortunately seem to do so.³³

If this dissertation has been successful, then you, the reader should have a sense that what Miriam Lee is doing in this passage is deeply connected to the way she practices acupuncture even though it does not involve needling and rests only lightly on Chinese medical concepts. Inversely, you should also be prepared to see the act of needling as akin to Lee’s hymns of praise. Ethnography, as I imagine it in this dissertation, is a way

³³ Lee, Miriam. 1992. *Insights of a senior acupuncturist: One combination of points can treat many diseases*. Blue Poppy Press. 49.

of provisioning the reader. If nothing else, I would hope that anyone who reads this work feels prepared to recognize the spirit of therapeutic activity that takes place in American acupuncture practice today.

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EDUCATION

Johns Hopkins University PhD in Anthropology	2010 – 2019
Oregon College of Oriental Medicine Master's Program in Acupuncture and Oriental Medicine	2000 – 2003
Reed College Bachelor of Arts degree with major in Physics	1995 – 1999

PROFESSIONAL APPOINTMENTS

Adjunct professor <i>Georgetown University</i> , Culture and Politics Program	2018 – 2019
Research assistant and fieldworker <i>Johns Hopkins School of Public Health</i> , SAPPHIRE Study	2015 – 2016

PUBLICATIONS

“An Ethnographic Exploration of Police Practices towards Street-based Female Sex Workers.” <i>Social Science and Medicine</i> [under review]	2018
“To Walk Alongside: Myth, Magic, and Mind in The Golden Bough.” <i>HAU: Journal of Ethnographic Theory</i>	2016

GRANTS & FELLOWSHIPS

Medical Humanities Fellowship The Johns Hopkins Center for Medical Humanities and Social Medicine	2017 – 2018
Dean's Teaching Fellowship The Johns Hopkins University	2018
Advanced Media Studies Fellowship The Johns Hopkins Center for Advanced Media Studies	2016 – 2017
James and Sylvia Thayer Short-term Research Fellowship Special Collections at the UCLA library	2016
Summer Research Grant The Johns Hopkins Program for the Study of Women, Gender, and Sexuality	2011

CONFERENCE ACTIVITY

– Events Organized –

- A Public Dialogue on Safety and Policing in Baltimore Apr 26, 2018
- Arty-facts of Ethnography: Art and Anthropology in Conversation Apr 19, 2017
Johns Hopkins Anthropology Department
- Interpreting Scientific Experience: Workshop and Reading Group 2015 – 2016
Johns Hopkins Anthropology Department
- Reclaiming Truth: Obligations, Methodologies, and Implications Apr 19–20, 2013
Johns Hopkins Anthropology Department graduate student conference
- Living Names: Encountering Naming Ethnographically Mar 10, 2012
Johns Hopkins Anthropology Department

– Panels Organized –

- Structure After Structuralism Roundtable Nov 29, 2017
2017 Annual meeting of the American Anthropological Association
- Police Un/Bound: New Ethnographies of Policing Panel Nov 17, 2016
2016 Annual meeting of the American Anthropological Association

– Panel Presentations –

- You Cannot Form the Words: Diagnosis, Fragmentation, and the Presence of Illness Oct 19, 2018
Johns Hopkins Center for Medical Humanities and Social Medicine workshop: “The Work of Diagnosis”
- The Body as Stranger: A Case Study of Acupuncture in the Midst of a Cancer Scare Apr 4, 2018
Johns Hopkins Anthropology 2018 Graduate Conference: “Being with Others”
- How to Read Ethnography: From Zora Neale Hurston to James Baldwin Mar 30, 2018
Anthropology and Literature workshop at Johns Hopkins
- Holding a Space: Locating Therapy in Two American Acupuncture Clinics Jan 30, 2018
The Johns Hopkins Anthropology Colloquium Series
- Spaces that Heal: Therapy and Material in an American Acupuncture Clinic Dec 8, 2017
Princeton Anthropology 2017 Graduate Conference: “Ethical and Political Materialities”
- Impressions of American Acupuncture: The Needle as Transitional Object Apr 20, 2017
The Fellows Symposium at the Hopkins Center for Advanced Media Studies
- Ours are the Ordinary Struggles: Cynicism and Uncertainty on a Sex Worker’s Stroll Nov 19, 2016
2016 Annual meeting of the American Anthropological Association

- Life on Patrol: An Ethnographic Examination of Police Work on the Streets of Post-Freddie-Gray Baltimore Nov 17, 2016
2016 Annual meeting of the American Anthropological Association
- A Labor of Love: Work and American Life in Acupuncture and Anthropology Mar 27, 2015
Johns Hopkins Anthropology 2015 Graduate Conference: "Affecting Labor"
- When I Walk Out, Something is Better: Acupuncture, Healing, and "Reagency" Mar 14, 2015
Program for Women, Gender, and Sexuality at Johns Hopkins Workshop with Karen Barad
- What is the Name of this Medicine? Uncovering National and Public Making Projects Feb 28, 2014
Johns Hopkins East Asian Studies 1st Annual Symposium on Public Health in Asia
- Assessing Diagnosis: A Performative Theory Approach to the Language of Contemporary East Asian Medicine in the United States Sept 11, 2013
8th International Congress on Traditional Asian Medicine
- Meta-synthesis of Qualitative Studies on Patient Experiences of East Asian Medicine Apr 11, 2013
8th Annual Congress of the International Society for Complementary Medicine
- Scientific Inquiry and the Enhancement of Tradition: Rethinking the Role of Inheritance for Chinese Medicine in the United States Apr 28, 2012
New School for Social Research 2012 Graduate Student Conference: "Inheritance"
- Only Ghosts Know: Name Play in the Chinese Translation of a Tintin Adventure Mar 10, 2012
"Living Names" workshop by the Johns Hopkins Department of Anthropology
- Touching the Subjectless Self: Intimate Transitions in Community Acupuncture Apr 6, 2012
Program for Women, Gender, and Sexuality at Johns Hopkins Annual Seminar
- Betrayal and Community Acupuncture: Concept, Object, Method, Moment Dec 1, 2011
The Johns Hopkins Anthropology Colloquium Series
- Archaeological Practice and the Entanglement of Tools Apr 16, 2011
Stanford Archaeology Center 2011 Graduate Student Conference: "Entanglement in Archaeology"
- **Discussant** –
- Crafting Aspiration through Creative Forms Apr 19, 2017
Johns Hopkins Anthropology 2015 Graduate Conference: "Enacting Aspiration"

TEACHING EXPERIENCE

Courses Designed and Taught

Foreign Bodies in Politics and Medicine
Police in Ethnographic Perspective
Diagnosis and Medical Power in Global Perspective

Teaching Assistant

Science, Medicine, and Media
Ethnographic Methods
Medical Anthropology
Anthropology of Media
Freshman Seminar in Anthropology
The Primitive and the Savage

CLINICAL EXPERIENCE

Acupuncturist – Out-patient hospital setting <i>The Teal Center at Virginia Hospital Center, Arlington, Virginia</i>	2009 – 2013
Chinese Medical Practitioner – Private practice <i>Victor Kumar LAc PLLC, Washington, DC</i>	2009 – 2010
Chinese Medical Practitioner – Integrated clinic <i>Creative Wellness, East Lansing, Michigan</i>	2005 – 2008
Acupuncturist and Clinical Manager – Integrated clinic <i>North Star Natural Health, Philadelphia, Pennsylvania</i>	2003 – 2005